ICICI Lombard General Insurance Company Limited

&

ICICI Prudential Life Insurance Company Limited

Product “iShield”

(Health Plus Life Combi Products”)

Policy Wordings - Health AdvantEdge

b. PREAMBLE:

The insurance cover provided under this Policy to the Insured / Insured Person up to the Sum Insured is and shall be subject to (a) the terms and conditions of this Policy and (b) the receipt of premium and (c) Disclosure to Information Norm (including by way of the Proposal) and (d) Schedule of Benefits.

c. SECTION 1 - DEFINITIONS:

Any word or expression to which a specific meaning has been assigned in any part of this Policy or the Schedule shall bear the same meaning wherever it appears. For purposes of this Policy, the terms specified below shall have the meaning set forth:

i. Standard Definitions (Definitions whose wordings are specified by IRDAI)

"Accident" is a sudden, unforeseen and involuntary event caused by external, visible and violent means.

"Any one Illness" means continuous period of Illness and it includes a relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment may have been taken.

"AYUSH Day Care Centre" means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:

i. Having qualified registered AYUSH Medical Practitioner(s) in charge;

ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

"AYUSH Hospital" An AYUSH Hospital is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

a. Central or State Government AYUSH Hospital; or
b. Teaching hospital attached to AYUSH College recognized by the Central
c. Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
d. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any

recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:

i. Having at least 5 in-patient beds;
ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
iii. Having dedicated AYUSH therapy sections as required and/or has equipped
iv. operation theatre where surgical procedures are to be carried out;
v. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

"Cashless facility" means a facility extended by the Insurer to the Insured where, the payments of the costs of treatment undergone by the Insured in accordance with the Policy terms and conditions are directly made to the network provider by the Insurer to the extent pre-authorization approved.

"Condition Precedent" shall mean a Policy term or condition upon which the Insurer's liability under the Policy is conditional upon.

"Congenital Anomaly" refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

Internal Congenital Anomaly - Congenital Anomaly which is not in the visible and accessible parts of the body is called Internal Congenital Anomaly.
External Congenital Anomaly - Congenital Anomaly which is in the visible and accessible parts of the body is called External Congenital Anomaly.

"Cumulative Bonus" shall mean any increase in the Sum Insured granted by the Insurer without an associated increase in the premium**.**

"Co Payment" shall mean a cost sharing requirement under a health Insurance policy that provides the policy holder/insured will bear a specified percentage of the admissible claims amount**.** A co payment does not reduce the Sum Insured

"Day Care treatment" means medical treatment, and / or surgical procedure which is:

i. undertaken under general or local anesthesia in a hospital/day care centre in less than 24 hours because of technological advancement, and
ii. which would have otherwise required a hospitalization of more than 24 hours.

Treatment normally taken on an out-patient basis is not included in the scope of this definition.

"Day care Centre" means any institution established for day care treatment of Illness and / or

injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner and must comply with all minimum criteria as under:

i. has qualified nursing staff under its employment
ii. has qualified medical practitioner/s in charge;
iii. has a fully equipped operation theatre of its own where surgical procedures are carried out
iv. maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.

"Deductible" is a cost-sharing requirement applicable per event/claim under a

health insurance Policy that provides, the Insurer will not be liable for a specified rupee amount in case of indemnity policies and/or for a specified number of days/hours in case of hospital cash benefit which will apply before any benefits are payable by the Insurer. A deductible does not reduce the Sum Insured.

"Dental Treatment:" Dental treatment means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

"Disclosure to information norm" means the Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

"Domiciliary hospitalization" means medical treatment for an Illness/Disease/Injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

i. the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
ii. the patient takes treatment at home on account of non-availability of room in a hospital.

"Emergency care" means management for a severe Illness or Injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the Insured person's health.

"Grace Period" means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a Policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

"Hospital" - A hospital means any institution established for in-patient care and day care treatment of Illness and/ or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act or complies with all minimum criteria as under:

i. has qualified nursing staff under its employment round the clock;
ii. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
iii. has qualified medical practitioner(s) in charge round the clock;
iv. has a fully equipped operation theatre of its own where surgical procedures are carried out;
v. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

"Hospitalization" means admission in a hospital for a minimum period of 24 in-patient care consecutive hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

“Illness" means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment.

a. **Acute condition** - Acute condition is a disease, Illness or Injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ Illness/ Injury which leads to full recovery.
b. **Chronic condition -** A chronic condition is defined as a disease, Illness, or Injury that has one or more of the following characteristics:
    i. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests;
    ii. it needs ongoing or long-term control or relief of symptoms;
    iii. it requires your/Insured person’s rehabilitation or for you/Insured member to be specially trained to cope with it;
    iv. it continues indefinitely;
    v. it recurs or is likely to recur

"Injury" means accidental physical bodily harm excluding Illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.

"Inpatient care" means treatment for which the Insured person has to stay in a hospital for more than 24 hours for a covered event.

"Intensive Care Unit" means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated Medical Practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

ICU (intensive Care Unit) Charges:- means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

"Maternity expense" shall include

a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization).
b. Expenses towards lawful medical termination of pregnancy during the Policy period.

“Medical Practitioner" is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction and is acting within the scope and jurisdiction of license. The term Medical Practitioner includes a physician, specialist and surgeon, provided that this person is not a member of the Insured/ Insured Person's family who includes Father, Mother, Father-in-law, Mother-in-law, Son, Daughter, Son-in-law, Daughter-in-law, Brother or Sister.

"Medical expenses" means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been Insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

"Medically Necessary" treatment is defined as any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:

i. is required for the medical management of the Illness or Injury suffered by the Insured;
ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
iii. must have been prescribed by a medical practitioner,
iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

"Medical Advise" means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

"**Migration**" means, the right accorded to health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

"Network Provider" means hospitals or health care providers enlisted by an Insurer or by a TPA and Insurer together to provide medical services to an Insured on payment by a cashless facility.

"Non- Network Provider" means any hospital, day care centre or other provider that is not part of the network.

"Notification of claim" means the process of intimating a claim to the Insurer or TPA through any of the recognized modes of communication.

"OPD treatment" is one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

"Portability" means, the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.

"Post-hospitalization Medical Expenses" means Medical Expenses incurred immediately after the Insured Person is discharged from the hospital provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

"Pre-Existing Disease" (PED) means any condition, ailment, injury or disease:

a. That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or it's reinstatement **OR**
b. For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy or its reinstatement.

"Pre-hospitalization Medical Expenses" means medical expenses incurred immediately before the Insured Person is Hospitalized, provided that:

a. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
b. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

"Qualified Nurse" is a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

"Renewal" defines the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of all waiting periods.

"Reasonable and Customary charges" means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the Illness / Injury involved.

"Room rent" means the amount charged by a hospital for the occupancy of a bed on per day (24 hours) basis and shall include associated medical expenses.

"Subrogation" mean the right of the insurer to assume the rights of the Insured person to recover expenses paid out under the Policy that may be recovered from any other source.

"Surgery" or Surgical Procedure" means manual and / or operative procedure (s) required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a hospital or day care centre by a medical practitioner.

"Unproven/Experimental treatment" is treatment, including drug Experimental therapy, which is not based on established medical practice in India, is treatment experimental or unproven.

ii. <u>Specific definitions (Definitions other than those mentioned under c (i) above)</u>

"Ayush Treatment" refers to the medical and / or hospitalization treatments given under 'Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

"Company" means ICICI Lombard General Insurance Company Limited.

"Dependent Child" means a child (natural or legally adopted), who is unmarried, aged between 91 days and 25 years, financially dependent on the Insured and does not have his / her independent sources of income.

"Disease" means an alteration in the state of the body or of some of its organs, interrupting or disturbing the performance of the functions, and causing or threatening pain and weakness or physical or mental disorder and certified by a Medical Practitioner.

"Diagnostic Tests" Investigations, such as X-Ray or blood tests, to find the cause of your symptoms and medical condition.

"Family" means a family described as such in the Schedule where Insured and Insured's Dependents named in the Schedule are insured under this Policy

"Family Floater Policy" means a Policy in terms of which, two or more persons of a Family are named in the Schedule as Insured Persons.

"Insured" / "Insured Person" means means the individual(s) whose name(s) is/are specifically appearing as such in the Policy Schedule and is/are hereinafter referred as "You"/"Your"/ "Yours"/ "Yourself"

"**New Born Baby**" baby born during the Policy Period and is aged upto 90 days.

"Policy period" means the period between the inception date and the expiry date as specified in the Schedule to this Policy or the cancellation of this insurance, whichever is earlier.

"Policy" means this document of Policy describing the terms and conditions of this contract of insurance (basis the statements in the Proposal Form) , any annexure thereto, the Schedule attached to and forming part of this Policy and any applicable endorsement thereon. The Policy contains details of the scope and extent of cover available to the Insured/Insured Person, the exclusions from the scope of cover and the terms and conditions of the issue of the Policy.

"Policy Year" means the period of one year commencing on the date of commencement specified in the Schedule of Insurance Certificate or any anniversary thereof.

" Restore Benefit" means re-instatement of hundred percent of the Sum Insured.

"Schedule" means Schedule attached to and forming part of this Policy mentioning the details of the Insured/ Insured Persons, the Sum Insured, the period and the limits to which benefits under the Policy are subject to.

"Schedule of Benefits" means the Product Benefits Table issued by the Company and accompanying this Policy and annexures thereto.

"Service provider" means any person, organization, institution, or company that has been empanelled with Us to provide services specified under the Benefits (including add-ons) to The Insured person. These shall also include all healthcare providers empanelled to form a part of network other than hospitals.

The list of the Service Providers is available at our website (https://www.icicilombard.com/content/ilom-en/serviceprovider/search.asp)and is subject to amendment from time to time

"Sum Insured" or Annual Sum Insured means the sum as specified in the Schedule to this Policy against the name of Insured / each Insured Person at the inception of a Policy Year and in the event of Policy is upgraded or downgraded on any continuous Renewal, then exclusive of Cumulative Bonus, if any, the Sum Insured for which premium is paid at the commencement of the Policy Year for which the prevalent upgrade or downgrade is sought.

"Terrorism/Terrorist Incident" means any actual or threatened use of force or violence directed at or causing damage, Injury, harm or disruption, or the commission of an act dangerous to human life or property or government, with the stated or unstated objective of pursuing economic, ethnic, nationalistic, political, racial or religious interests, whether such interests are declared or not. Robberies or other criminal acts, primarily committed for personal gain and acts arising primarily from prior personal relationships between perpetrator(s) and victim(s) shall not be considered terrorist activity. Terrorism shall also include any act, which is verified or recognized by the relevant Government as an act of terrorism.

"Third Party Administrator (TPA)" means any organization or institution that is licensed by the IRDA as a TPA and is engaged by the Company for a fee or remuneration for providing Policy and claims facilitation services to the Insured/ Insured Person as well as to the Company for an insurable event.

You/Your/ Yours/ Yourself means the person(s) that We insure and is/are specifically named as Insured / Insured Person(s) in the Policy Schedule.

We/ Our/ Ours/ Us means the ICICI Lombard General Insurance Company Limited

d. Benefits covered under the Policy

The coverage mentioned below differs between the various plan offerings and the wordings of only the relevant covers opted by the Insured Person and as mentioned in the Policy schedule will be applicable.

SECTION 2 - SALIENT FEATURES & BENEFITS:

Basic cover:

The Company hereby agrees subject to the terms, conditions and exclusions herein contained or otherwise expressed, for the period and to the extent of the Sum Insured as specified in the Schedule to this Policy.

The Policy covers Reasonable and Customary Charges incurred towards medical treatment taken during the Policy Period for an Illness, Accident or condition described below if this is contracted or sustained by an Insured / Insured Person during the Policy Period and subject always to the Sum Insured, any subsidiary limit specified in the schedule of Benefits, the terms, conditions, limitations and exclusions mentioned in the Policy and eligibility as per the insurance plan opted by insured and stated in as stated in the Schedule

Section 2.1) In-patient Treatment:

This benefit provides cover for reimbursement / payment of cashless hospitalization expenses which are reasonably and necessarily incurred by the Insured / Insured Person for treatment of Disease, Illness contracted or Injury sustained by the Insured / Insured Person during the Policy period as specified in the Schedule to this Policy, in a Hospital in India for in- patient care which among other things, includes, Hospital room rent or boarding expenses, nursing, Intensive Care Unit Charges, Operation Theatre charges, Medical Practitioner's charges, fees of Surgeon, Anesthetist, Qualified Nurse, Specialists, the cost of diagnostic tests, medicines, drugs, blood, oxygen, the cost of prosthetics and other devices or equipment if implanted internally during a Surgical Procedure.

The Insured/Insured Person should have been hospitalized as an in-patient care for a minimum period of 24 consecutive hours. The benefit under this Section is limited to the Sum Insured specified for this Section in the Schedule of Benefits to this Policy.

Eligibility of room category as per the plan opted

For Insured / Insured Person opting for sum insured options 2Lacs/ 3Lacs / 4Lthe coverage for hospital room and / or boarding and nursing shall be subject to maximum per day capping of 1 % of the Sum Insured and in case of the coverage for Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses shall be subject to maximum per day capping of 2 % of the Sum Insured.

In case of admission to a room at rates exceeding the above limits, the reimbursement/payment of all other expenses incurred at the Hospital, be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent charges. However, cost of pharmacy and consumables; cost of implants and medical devices and cost of diagnostics shall be reimbursed at actuals. Proportionate deductions are not applicable on ICU charges and on hospitals which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on room category.

If the Insured Person is admitted in a Hospital room where the room category opted or Room Rent incurred is higher than the eligibility as specified in the Policy Schedule, then We shall be liable to pay only a pro-rated portion of the total Associated Medical Expenses (including surcharge or taxes thereon) as per the following formula, this is not applicable if the hospital does not follow differential billing or for those expenses in respect of which differential billing is not adopted based on the room category.

(Eligible Room Rent limit / Room Rent actually incurred) * total Associated Medical Expenses

Associated Medical Expenses shall include Room Rent excluding ICU charges, nursing charges for Hospitalization as an Inpatient, Medical Practitioners' fees , operation theatre charges and other supply of bill excluding Cost of pharmacy and consumables; Cost of implants and medical devices, Cost of diagnostics

Illustration:
Sum Insured – INR 400,000
Eligible Room Rent – INR 4,000
Room Rent actually incurred – INR8,000

Associated Medical Expenses Incurred – INR 50,000
Associated Medical Expenses Payable – INR 25,000
Basis of Calculation:
4,000/8,000 * 50,000 = INR 25,000

Section 2.2) Pre-hospitalization:

This benefit covers relevant medical expenses incurred during a period up to the number of days as specified in the Schedule of benefits forming part of this Policy, prior to hospitalization or day care treatment for treatment of Disease, Illness contracted or Injury sustained for which the Insured / Insured Person was hospitalized, giving rise to an admissible claim under this Policy. This benefit is a part of benefit available under Section 2.1 above and is limited to the available Sum Insured under Section 2.1. Pre-hospitalization Medical Expenses can be claimed as reimbursement only.

Section 2.3) Post-hospitalization:

This benefit covers relevant medical expenses incurred during a period up to the number of days as specified in the Schedule of benefits forming part of this Policy, after discharge from Hospital / day care treatment for continuous and follow up treatment of the Disease, Illness contracted or Injury sustained for which the Insured/Insured Person was hospitalized, giving rise to an admissible claim under this Policy. This benefit is a part of benefit available under Section 2.1 above and is limited to the available Sum Insured under Section 2.1. Post-hospitalization Medical Expenses can be claimed as reimbursement only.

Section 2.4) Organ Donor:

Where the Insured/Insured Person contracts any of the Illness or Injury requiring major Organ Transplantation surgery and undergoes surgery and treatment in a Hospital as an in-patient for which a valid claim under this Policy is admissible, the hospitalization expenses incurred for harvesting the organ donated for the Insured / Insured Person for this treatment is covered under this benefit, provided the donation conforms to The Transplantation of Human Organs Act 1994. This benefit is a part of benefit available under Section 2.1 above and is limited to the available Sum Insured under Section 2.1. This part of benefit is applicable throughout the policy period

This benefit also covers screening expenses of the donor if he/she is accepted as a donor. Post donation fitness test is also covered under this. Any medical expenses as a result of complications arising because of harvesting from the donor is also covered. However, this benefit does not cover costs directly or indirectly associated with the acquisition of the donor's organ. This part of the benefit is applicable for a period of six months or the policy end date whichever is earlier from the date of organ harvesting from the donor.

Section 2.5) Day Care Treatment:

This benefit covers hospitalization expenses towards medical treatment, and/or all day care procedures incurred by the Insured / Insured Person which is undertaken under General or Local

Anesthesia in a Hospital/day care centre (where 24 hours of hospitalization is not required due to technologically advanced treatment) which shall be payable. The benefit under this Section is limited to the available Sum Insured under Section 2.1 of this Policy as mentioned in the Schedule to this Policy.

Section 2.6 Ayush Treatment:

This benefit provides reimbursement to the Insured/ Insured Person of Medical Expenses incurred for In-patient treatment taken under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems provided that:

The treatment is undertaken in lines with definition of Ayush Day Care and Ayush Hospital

Note:

a) The reimbursement under Ayush benefit will be applicable for inpatient hospitalization claims only;

b) The Insured/ Insured person will not be entitled for Domiciliary Hospitalization;

c) Cashless facility is not available.

The benefit under this Section is available upto the Sum Insured under Section 2.1 of this Policy as mentioned in the Schedule to this Policy.

SECTION 3 – OTHER BENEFITS:

Benefits under this Section are payable as additional benefits / in-built benefits upto the limits specified in the Schedule to this Policy. However, the amount under this shall be part of the overall Sum Insured

Section 3.1 Restore Benefit

In case of a situation where the Sum Insured and Guaranteed Cumulative Bonus (GCB) are exhausted due to claims made and paid during the Policy Year, and the Insured/Insured Persons have to, incur any hospitalization expenses due to any Accident/ Disease/ Illness / Injury for which a valid claim is admissible under the Policy, then the Sum Insured shall be regained and called Regained Sum Insured which is equal to 100% of SI for the particular Policy year for all members in the Policy, provided that;

I. The Regained Sum Insured will be enforceable only after the first claim during the policy year. The regain benefit will be triggered upon partial or full utilization of Sum Insured. The Regained Sum Insured can be used for claims made by the Insured / Insured Person in respect of the benefits stated in Section 2. Hence making the total Sum Insured available as SI+GCB+Regain – (minus) 1st Claim
II. The Regained Sum Insured shall be available for any Accident / Disease / Illness / Injury or any related Accident / Disease / Illness/ Injury for which a Claim has already been admitted partially or fully for that Insured / Insured person during that Policy Year.
III. The Regain Sum Insured will only be allowed once during a Policy Year;
IV. Regain of Sum Insured is not applicable for Optional benefits.

If the Regain Sum Insured is not utilized in a Policy Year, it shall not be carried forward to any subsequent Policy Year.

Sample Illustration 1

Claim No	Sum Insured Available	Cumulative Bonus Available	Claim admissible amount	Regain Sum Insured	Total Sum Insured Available	Payable Amount	Balance Sum Insured
1	300000	NA	250000	NA	300000	250000	50000
2	50000	NA	250000	300000	50000 - Main Sum Insured 300000 - Regain Sum Insured	250000	100000

Sample Illustration 2

Claim No	Sum Insured Available	Cumulative Bonus Available	Claim admissible amount	Regain Sum Insured	Total Sum Insured Available	Payable Amount	Balance Sum Insured
1	500000	NA	250000	NA	500000	250000	250000
2	250000	NA	1000000	500000	250000 - Main Sum Insured 500000 - Regain Sum Insured	750000	0

In case of renewal

Sample Illustration 1

Year	Claim No	Sum Insured Available	Cumulative Bonus Available	Claim admissible amount	Regain Sum Insured	Total Sum Insured Available	Payable Amount	Balance Sum Insured
1	No Claim	500000	NA	NA	NA	500000	NA	NA
2	1	500000	100000	500000	NA	500000 - Main Sum Insured 100000 - Cumulative Bonus	500000	100000
	2	0	100000	300000	500000	0 - Main Sum Insured 100000 - GCB 500000 - Regain Sum Insured	300000	300000

Sample Illustration 4

Year	Claim No	Sum Insured Available	Cumulative Bonus Available	Claim admissible amount	Regain Sum Insured	Total Sum Insured Available	Payable Amount	Balance Sum Insured
1	No Claim	500000	NA	NA	NA	500000	NA	NA
2	1	500000	100000	500000	NA	500000 - Main Sum Insured	500000	100000

						100000 - Cumulative Bonus		
	2	0	100000	300000	500000	0 - Main Sum Insured 100000 - GCB 500000 - Regain Sum Insured	300000	300000
3	1	500000	100000	500000	NA	500000 - Main Sum Insured 100000 - Cumulative Bonus	500000	100000
	2	0	100000	300000	500000	0 - Main Sum Insured 100000 - GCB 500000 - Regain Sum Insured	300000	300000

3.2 Animal Bite (Vaccination)

The Company will cover Medical Expenses of OPD Treatment for vaccinations or immunizations for treatment post an animal bite, up to the limit provided in the Schedule of Benefits. This benefit is available only on reimbursement basis.

3.3 Guaranteed Cumulative Bonus (GCB):

If no claim has been made in a Policy Year by any Insured / Insured Person, then for each such Policy year, the Company will offer a GCB of 20% of Sum Insured maximum uptill 100% of expiring or renewed Policy Sum Insured, whichever is lower

Guaranteed **Cumulative Bonus** will be provided on the expiring/ renewed Policy Sum Insured, whichever is lower, provided that the Policy is renewed continuously.

The sub-limits applicable to various benefits will remain the same and shall not increase proportionately with the increase in Guaranteed Cumulative Bonus.

This will not affect the Sum Insured of the Policy.

Guaranteed Cumulative Bonus will be available only for base cover benefits

Once accrued Guaranteed cumulative bonus shall remain guaranteed for the life (i.e. will not get reduced on subsequent renewals) and shall not get reduced in case of a claim irrespective of value of GCB accrued / Maximum value of GCB that can be accrued is 100% of expiring or renewed policy sum insured, whichever is lower.

IllustrationLet us assume that an individual has opted for a Sum Insured of INR 500,000 and has continuously renewed the policy for next 4 years. The Guaranteed cumulative bonus is as illustrated below:

Year	Sum Insured Available	Guaranteed Cumulative Bonus Available (20% of Sum Insured)	Total Sum Insured Available (Base + GCB)	Claim / No Claim
Year 0	500000	NA	500000	No Claim
Year 1	500000	100000	600000	No Claim
Year 2	500000	200000 (100000 + 100000)	700000	Claim
Year 3	500000	200000 (100000+ 100000 + 0)	700000	Claim

Year 4	500000	200000 (100000+ 100000 +0 +0)	700000	

3.4 Surface Ambulance Charges:

This benefit provides for cashless / reimbursement to the Insured/Insured Person of expenses incurred for his/her surface transport by ambulance to hospital or between hospitals and/or diagnostic center for treatment of Disease, Illness or Injury in a Hospital as an in-patient for which a valid claim under this Policy is admissible.

This benefit is subject to sub limits (per hospitalization claim) as mentioned in Schedule of benefit but within overall limit of the Sum Insured as specified in the Schedule to this Policy.

This benefit is applicable irrespective of the number of occurrences during the Policy period subject to the overall Sum Insured.

3.5 Health Check-up:

The Company will cover the cost of health checkup on cashless basis as per plan eligibility as defined in the Policy schedule provided that Insured / Insured Person is covered within overall SI limit under section 2.1. Only that Insured / Insured Person who has attained minimum age of 18 years at the time of first policy/Renewal shall be eligible for a health check-up.

3.6 Convalescence Benefit:

In case the Insured / Insured Person is hospitalized for a continuous period of 10 days or more for treatment of any Accident / Disease/ Illness /Injury for which a valid claim is admissible under the Policy, this benefit provides for payment to the Insured / Insured Person of a fixed allowance as mentioned in the Schedule of benefit attached to this Policy.

This benefit is subject to sub limits as mentioned in Schedule of benefits payable only once during the Policy year.

If an insured is taking a coverage for 1 year he is eligible for convalescence benefit only once (i.e. one per policy year), while if he is taking the policy coverage for 3 years, he is then eligible for this benefit once in each and every year (i.e. one per policy year).

3.7: Bariatric Surgery Cover:

If the insured is hospitalized on the advice of a Doctor because of Conditions mentioned below which required insured to undergo Bariatric Surgery during the Policy year, then We

will pay the insured, Reasonable and Customary Expenses related to Bariatric Surgery according to the policy schedule and waiting period mentioned in this document. There is no limit on the number of time this cover can be used in a policy year subject to the Sum Insured of the cover as specified in policy schedule.

Eligibility:

For adults aged 18 years or older, presence of severe obesity documented in contemporaneous clinical records defined as any of the following:

BMI greater than and equal to 40 in conjunctions with any of the following severe comorbidities:

1. Coronary heart disease; or

2. Medically refractory hypertension (blood pressure greater than 140 mm Hg systolic and/or 90 mm Hg diastolic despite concurrent use of 3 anti-hypertensive agents of different classes); or

3. Type 2 diabetes mellitus

Special Conditions applicable to Bariatric Surgery Cover

• Bariatric surgery performed for any other reason not listed above shall not be covered.

• The indication for the procedure should be found appropriate by two qualified surgeons and the insured person shall obtain prior approval of the company for cashless treatment. This optional benefit helps insured in availing bariatric treatment if suggested by attending doctor

3.8) Domiciliary Hospitalization:

Medical treatment for an Illness/Disease/Injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:

1. The condition of the Patient is such that he/she is not in a condition to be removed to a Hospital or,

2. The Patient takes treatment at home on account of non-availability of room in a Hospital.

However, this does not cover

1. Treatment of less than 3 days. (Coverage will be provided for expenses incurred in first three days however this benefit will be applicable if treatment period is greater than 3 days);

2. The following medical conditions:

a. Asthma, Bronchitis, Tonsillitis and Upper Respiratory Tract infection including Laryngitis and Pharyngitis, Cough and Cold, Influenza,

b. Arthritis, Gout and Rheumatism,

c. Chronic Nephritis and Nephritic Syndrome,

d. Diarrhoea and all type of Dysenteries including Gastroenteritis,

e. Diabetes Mellitus and Insupidus,

f. Epilepsy,

g. Hypertension,

h. Pyrexia of unknown origin.

Domiciliary hospitalization benefits also cover expenses on Qualified nurses engaged on the recommendation of the attending Medical Practitioner.

The benefit under this Section is limited to the available Sum Insured under Section 2.1 of this Policy as mentioned in the Schedule to this Policy.

3.9) Zonal Pricing

For the purpose of calculating premium below zones are available:-

Zone 1:- NCR, Mumbai, Thane district, Raigad District (Maharashtra), Navi Mumbai, Gujrat , Kolkata .

Zone 2:- Hyderabad, Secunderabad, Chhattisgarh, Madhya Pradesh, Daman & Diu, Dadar & Nagar Haveli, Goa, Maharashtra (excluding Mumbai, Thane District, Raigad District (Maharashtra), Navi Mumbai)

Zone 3:- Rest of India (excluding as mentioned in Zone 1 and Zone 2).

If you select Zone 1 during proposal inward and if treatment is taken in zone 1 then no copay will be applicable.

If you select Zone 2 during proposal inward and if treatment is taken in zone 1 then 12.5% copay will be applicable.

If you select Zone 3 during proposal inward and if treatment is taken in zone 2 then 12.5% copay will be applicable.

If you select Zone 3 during proposal inward and if treatment is taken in zone 1 then 15% copay will be applicable.

Cities included in the zone	Discount on Premium	Co-pay on claim
Zone 1 – NCR, Mumbai, Thane district, Raigad District (Maharashtra), Navi Mumbai, Gujrat , Kolkata	No Discount	No co-pay on claim anywhere in India
Zone 2 – Hyderabad, Secunderabad, Chhattisgarh, Madhya Pradesh, Daman & Diu, Dadar & Nagar Haveli, Goa, Maharashtra (excluding Mumbai, Thane District, Raigad District (Maharashtra), Navi Mumbai)	Discount on premium – 12.50%	Treatment taken at locations included in Zone 1: 12.5% co-pay Treatment taken at locations included in Zone 2 & 3 – no co-pay
Zone 3 – Rest of India	Discount on premium – 15%	Treatment taken at locations included in Zone 1: 15% co-pay Treatment taken at locations included in Zone 2 – 12.5% co-pay Treatment taken at locations included in Zone 3 – no co-pay

NCR*	**Name of the Districts**
Haryana	Faridabad, Gurugram, Nuh, Rohtak, Sonepat, Rewari, Jhajjhar, Gurugram, Panipat, Palwal, Bhiwani,Charkhi Dadri, Mahendragarh, Jind and Karnal
Uttar Pradesh	Meerut, Ghaziabad, Noida/ Gautam Budh Nagar, Bulandshahr, Baghpat, Hapur,Shamli and Muzaffarnagar
Rajasthan	Alwar and Bharatpur
Delhi	Whole of NCT Delhi.

3.10 Incentives associated with Vaccination against pneumococcal disease

We will provide an additional 1.5% discount on premium (fresh or renewal) for Insured Person who have taken the conjugate Pneumococcal vaccine which helps prevent pneumococcal disease. All the adult members covered under the policy should have been vaccinated in the past one year (1 year) from policy start date to avail this discount. i.e. if policy start date is 1st January 2022, all adult members under the policy should have been vaccinated against Pneumococcal disease in the period from 1st January 2021 to 31st December 2021. This discount shall be provided lifetime as long as the Insured person continues to renew this policy

SECTION 4 – OPTIONAL BENEFIT:

Benefits under this Section are payable as optional benefits on payment of additional premium, up to the limits specified in the Schedule to this Policy unless specified otherwise.

4.1: Domestic Air Ambulance:

In consideration of the payment of additional premium to Us, We will cover the expenses incurred on air ambulance services in respect of an Insured Person which are offered by a healthcare or an air ambulance service provider and which have been used during the Policy Period to transfer the Insured Person to the nearest Hospital with adequate emergency facilities for the provision of Emergency Care, provided that:

i. Our maximum liability under this Benefit for any and all claims arising during the Policy Year will be restricted to the Sum insured as stated in the Policy Schedule;
ii. It is for a life threatening emergency health condition/s of the Insured Person which requires immediate and rapid ambulance transportation from the place where the Insured Person is situated at the time of requiring Emergency Care to a hospital provided that the transportation is for Medically Necessary Treatment, is certified in writing by a Medical Practitioner, and road ambulance services cannot be provided.
iii. Such air ambulance providing the services, should be duly licensed to operate as such by a competent government Authority.
iv. This cover is limited to transportation from the area of emergency to the nearest Hospital only;
v. We will not cover:
    a) Any transportation from one Hospital to another;
    b) Any transportation of the Insured Person from Hospital to the Insured Person's residence after he/she has been discharged from the Hospital
    c) Any transportation or air ambulance expenses incurred outside the geographical scope of India.
vi. We have accepted a claim under Section In patient treatment in respect of the Insured Person for the same Accident/Illness for which air ambulance services were availed.
vii. We shall not be liable if Medically Necessary Treatment can be provided at the Hospital where the Insured Person is situated at the time of requiring Emergency Care.

4.2: Maternity Cover:

This optional benefit covers the medical expenses including up to limits specified in the schedule (over and above Sum Insured mentioned in the Schedule) for the delivery of a baby and / or expenses related to medically recommended lawful termination of pregnancy but only in life threatening situation under the advice of Medical Practitioner, limited to maximum of three deliveries or terminations as said herein during the lifetime of an female Insured/Insured Person as the case may be between the ages of 18 years to 45 years in the Policy.

The benefit will have a waiting period of 9 months from the time this cover is opted for

This optional benefit is applicable to all or any female Insured / Insured person who has opted for 3 years Policy term between age 18 to 45 years as selected by proposer.

In case, insured has taken three year policy without maternity optional benefit and would like to opt for maternity optional benefit, then this can be availed only at the time of renewal

Ectopic Pregnancy is not covered under this section. In case the maternity benefit is not claimed, next 3 years maternity premium is waived off. Exclusion No, '**R. Maternity: Code Excl18' will not be applicable to this section**

4.3: New Born Baby Cover:

Medical Expenses for any medically necessary treatment described at 2.1 while the Insured Person (the Newborn baby) is hospitalized during the Policy Period within first 90 days of birth, as an inpatient under this benefit. The coverage is subject to the Policy exclusions, terms and conditions. This Benefit is applicable if Maternity benefit is opted and the Company has accepted a maternity claim under this Policy.

This benefit is subject to the specified limits as mentioned in Schedule however over and above the Maternity sum insured mentioned in the Schedule.

4.4: Vaccinations for new born baby in the first year

Vaccinations for new born baby till one year of age during the policy period - Option of covering vaccination for the new born baby which is upto 1% of Sum Insured or upto Rs. 10,000 whichever is lesser. This Benefit is applicable if Maternity benefit is opted and the Company has accepted a maternity claim under this Policy.

This benefit is subject to the specified limits as mentioned in Schedule however over and above the Maternity sum insured mentioned in the Schedule

4.5: OPD for Medical and Dental:

This optional cover help you in getting your bill reimbursed upto the limit specified in the schedule. The OPD benefit will cover the following on reimbursement basis

- In-network Doctor Consultation on submission of consultation papers

- In-network Pharmacy on submission of prescription.

- In-network diagnostics on submission of diagnostic reports

-In-network Physiotherapy on submission of consultation papers

This benefit is subject to the specified limits as mentioned in Schedule however over and above the Sum Insured mentioned in the Schedule. Exclusion No, '**U' will not be applicable to this section**

Illustration

SI	OPD SI Eligibility
1000000	5000
10000000	50000
30000000	100000

4.6: Hospital Cash Benefit:

Daily cash amount will be payable per day up to the specified limits as mentioned in the Schedule to this Policy if the Insured Person is Hospitalized for treatment of any Disease / Illness / Injury for which a valid claim is admissible under the Policy for each continuous and completed period of 24 hours and if the Hospitalization exceeds for more than 24 hours. First continuous and completed period of 48hours will act as deferment which means minimum hospitalization of 48 hours is required for claims to be payable from the time of hospitalization.

This is paid up to a maximum of 45 days for all Insured Persons.

This benefit is subject to the specified limits as mentioned in Schedule over and above the Sum Insured as mentioned in the Schedule.to this policy.

4.7: Personal Accident Cover:

This optional benefit helps insured in getting additional coverage of following benefits upto the Sum Insured opted for:

a. Accidental Death

We shall pay 100% of the coverage amount of the Insured / Insured Person, in the event of his / her Death on account of an Accident / Injury, during the Policy Period or within twelve calendar months from the date of occurrence of such Accident / Injury which occurred during Policy Period.

b. Permanent Total Disablement

We shall pay up to the coverage amount of the Insured Person as specified below in case of his / her permanent total disablement on account of any Accident / Injury, during the Policy Period or within twelve calendar months from the date of occurrence of such Accident / Injury which occurred during Policy Period. The payout of the Sum Insured shall be as per table below:

S.No	Insured Events	Amount payable = % of the Sum Insured specified in the policy schedule
I	Total and irrecoverable loss of sight of both the eyes or the actual loss by physical separation of two entire hands or feet, or one entire hand and one entire foot, or the total and irrecoverable loss of sight of one eye and loss by physical separation of one entire hand or one entire foot.	100%
II	Total and irrecoverable loss	100%
	(a) use of two hands or two feet	
	(b) one hand and one foot	
	(c)sight of one eye and use of one hand or one foot	
III	Total and irrecoverable loss of sight of one eye or the actual loss by physical separation of one entire hand or one entire foot	50%
IV	Total and irrecoverable loss of use of one entire hand or one entire foot without physical separation	50%
V	Paraplegia or Quadriplegia or Hemiplegia	100%

NOTE: For the purpose of Sr. No. I to IV in the table above, physical separation of a hand or foot shall mean separation of the hand at or above the wrist, and of the foot at or above the ankle.

For the purpose of this Benefit only:

(I) "Hemiplegia" means complete and irrecoverable paralysis of the arm, leg, and trunk on the same side of the body;

(II) "Paraplegia" means complete and irrecoverable paralysis of the whole of the lower half of the body (below waist) including both the legs;

(III) "Quadriplegia" means complete and irrecoverable paralysis of all four limbs.

c. Permanent Partial Disablement

We shall pay up to the coverage amount of the Insured Person as specified below in case of his / her permanent partial disablement on account of any Accident / Injury, during the Policy Period or within twelve calendar months from the date of occurrence of such Accident / Injury which occurred during Policy Period. The payout of the Sum Insured shall be as per table below:

S.No	Insured Events	Amount payable = % of the Sun Insured specified in the policy schedule
I	Total and irrecoverable loss of hearing in: -	
	a) Both ears	75%
	b) One ear	30%
II	Loss of toes	
	a) All	20%
	b) Both phalanges of great toes bilateral	5%
	c) Both phalanges of one great toe	2%
	d) Both phalanges of other than great than great toes for each	1%
III	III Loss of four fingers and thumb of one hand	40%

IV	Loss of four fingers of one hand	35%
V	Loss of thumb	
	a) Both phalanges	25%
	b) One phalanx	10%
VI	Loss of index finger	
	a) Three phalanges	10%
	b) Two phalanges	8%
	c) One phalanx	4%
VII	Loss of middle finger	
	a) Three phalanges	6%
	b) Two phalanges	4%
	c) One phalanx	2%
VIII	Loss of ring finger	
	a) Three phalanges	5%
	b) Two phalanges	3%
	c) One phalanx	2%
IX	Loss of little finger	
	a) Three phalanges	4%
	b) Two phalanges	3%
	c) One phalanx	2%
X	Loss of metacarpus	
	a) First or second	3%
	b) Third, fourth or fifth	2%
XI	Permanent partial disablement not otherwise provided for under serial no. I to X	Such % of the Sum Insured as determined in accordance with the medical assessment carried out by the Company's Network Hospital that the %age under Insured event Sr. No. XI shall not exceed 50% of the Sum Insured

4.8: Critical Illness:

After waiting period as specified in the policy schedule (mentioned as Waiting Period), if the Insured is at any time during the Policy period, being diagnosed contracted by any Critical Illness as specified below and surviving for more than such period mentioned in Schedule mentioned as Critical Illness Survival Period, post such diagnosis, (over and above the Sum Insured mentioned in the Schedule), Insured shall be paid Lump Sum amount upto the specified limits as mentioned in Schedule.

After availing the benefit under section Critical Illness, if the Insured / Insured Person takes treatment for the Critical Illness in a Hospital, the hospitalization expenses incurred for the same would be payable/reimbursed, subject to the terms and conditions of the Policy, out of the Sum Insured available for Hospitalization Benefit cover under Section In patient Treatment of this Policy. However, in case of diagnosis of multiple illnesses qualified as Critical Illness under the Policy, the payment of compensation under critical illness benefit shall be limited to the limit specified in the schedule and shall be payable only once in the lifetime of Insured/Insured person. Critical Illness benefit will lapse after reporting of and payment of one claim for the claiming Insured/Insured person. Critical Illness limit opted cannot be more than Sum Insured opted for Section In patient Treatment The illnesses qualified as Critical Illnesses and covered in this section are as follows:

1. Cancer of Specified Severity
2. Myocardial Infarction **(**First Heart Attack of Specified Severity)
3. Coronary Artery Disease
4. Open Chest CABG
5. Open Heart Replacement or Repair of Heart Valves
6. Surgery to Aorta
7. Stroke resulting in Permanent Symptoms
8. Kidney Failure requiring Regular Dialysis
9. Aplastic Anaemia
10. End Stage Lung Disease
11. End Stage Liver Failure
12. Coma of Specified Severity
13. Third Degree Burns
14. Major organ /bone marrow transplant
15. Multiple Sclerosis with Persisting Symptoms
16. Fulminant Hepatitis
17. Motor Neurone Disease with Permanent Symptoms
18. Primary Pulmonary Hypertension
19. Terminal Illness
20. Bacterial Meningitis

1. Cancer of Specified Severity

A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.

The following are excluded –

i. All tumors which are histologically described as carcinoma in situ,benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not

limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.

ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;

iii. Malignant melanoma that has not caused invasion beyond the epidermis;

iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0

v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;

vi. Chronic lymphocytic leukaemia less than RAI stage 3

vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,

viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

2. Myocardial Infarction (First Heart Attack of specified severity)

The first occurrence of heart attack or myocardial infarction which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

I. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial Infarction (for e.g. typical chest pain)
II. New characteristic electrocardiogram changes
III. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded

I. Other acute Coronary Syndromes
II. Any type of angina pectoris
I. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3. Coronary Artery Disease

The narrowing of the lumen of at least one coronary artery by a minimum of 75% and of two others by a minimum of 60%, as proven by coronary arteriography, regardless of whether or not any form of coronary artery surgery has been performed. Coronary arteries herein refer to left main stem, left anterior descending circumflex and right coronary artery.

4. Open Chest CABG (Coronary Artery By-pass Graft) surgery

The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

The following are excluded:

I. Angioplasty and/ or any other intra-arterial procedures

5. Open heart replacement or repair of heart valves

The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/ valvuloplasty are excluded.

6. Surgery to Aorta

The actual undergoing of major surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen. For the purpose of this definition aorta shall mean the thoracic and abdominal aorta but not its branches.

Surgery performed using only minimally invasive or intra-arterial techniques are excluded.

Angioplasty and all other intra-arterial, catheter based techniques, "keyhole" or laser procedures are excluded.

7. Stroke resulting in permanent symptoms

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and

evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

The following are excluded:

I. Transient ischemic attacks (TIA)
II. Traumatic Injury of the brain
III. Vascular disease affecting only the eye or optic nerve or vestibular functions

8. Kidney failure requiring regular dialysis

End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

9. Aplastic Anaemia

Chronic persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least one of the following:

I. Blood product transfusion;
II. Marrow stimulating agents;
III. Immunosuppressive agents; or
IV. Bone marrow transplantation

The diagnosis must be confirmed by a haematologist.

10. End Stage Lung Disease

End Stage Lung Disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:

i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and

ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and

iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO2 < 55mmHg); and

iv. Dyspnea at rest.

11. End Stage Liver Failure

I. Permanent and irreversible failure of liver function that has resulted in all three of

the following:

i. Permanent jaundice; and

ii. Ascites; and

iii. Hepatic encephalopathy.

II. Liver failure secondary to drug or alcohol abuse is excluded.

12. Coma of specified severity

A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

I. no response to external stimuli continuously for at least 96 hours;
II. life support measures are necessary to sustain life; and
III. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

13. Third Degree Burns

I. There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

14. Major organ /bone marrow transplant

The actual undergoing of a transplant of:

I. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
II. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

The following are excluded:

I. Other stem-cell transplants
II. Where only islets of langerhans are transplanted

15. Multiple Sclerosis with persistent symptoms

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and

ii. there must be current clinical impairment of motor or sensory function,which must have persisted for a continuous period of at least 6 months.

I. Other causes of neurological damage such as SLE are excluded.

16. Fulminant Hepatitis

A sub-massive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure.

This diagnosis must be supported by all of the following:

I. Rapid decreasing of liver size;
II. Necrosis involving entire lobules, leaving only a collapsed reticular framework;
III. Rapid deterioration of liver function tests;
IV. Deepening jaundice; and
V. Hepatic encephalopathy.

17. Motor Neurone Disease with permanent symptoms

Motor neurone disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months

18. Primary Pulmonary Hypertension

I. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

II. The NYHA Classification of Cardiac Impairment are as follows:

i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.

ii. Class IV: Unable to engage in any physical activity without discomfort.Symptoms may be present even at rest.

III. Pulmonary hypertension associated with lung disease, chronic hypoventilation,pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart and any secondary cause are specifically excluded.

19. Terminal Illness

The conclusive diagnosis of an Illness that is expected to result in the death of the insured person within 12 months. This diagnosis must be supported by a specialist and confirmed by the Company's appointed Doctor.

20. Bacterial Meningitis

Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal cord resulting in significant, irreversible and permanent neurological deficit. The neurological deficit must persist for at least 6 weeks. This diagnosis must be confirmed by:

I. The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and
II. A consultant neurologist.

4.9 Worldwide Cover

In consideration of the payment of additional premium to Us, We will cover the Insured person for hospitalization expenses including planned hospitalisation incurred outside India and anywhere across the world including USA and Canada, up to the amount specified under against this benefit in the policy schedule subject to the terms & conditions specified hereunder:

I. A co-pay of 10% will be applied to every admissible claim over and above to any other co-pay charged
II. The benefit is available for 45 consecutive days from the date of travel in a single trip and 90 days in a cumulative bases as a whole in a Policy year
III. The expenses covered under this benefit will be limited to inpatient hospitalization expenses and days care treatment/ procedure expenses. Expenses incurred for pre and post hospitalization will not be covered under this benefit.
IV. The payment of any claim under this benefit will be based on the rate of exchange as on Date of Loss published by Reserve Bank of India (RBI) and shall be used for conversion of Foreign Currency into Indian rupees for payment of claims. If on the insured person's date of loss, if the RBI rates are not published, the exchange rates published next shall be considered for conversion
V. In case of planned hospitalization, prior intimation of the claim and due approval from Us will be necessary

4.10 Tele Consultation(s)

We will arrange consultations and recommendations for routine health issues by a qualified Medical Practitioner or health care professional. For the purpose of this benefit Telephonic/Virtual consultation shall mean consultation provided by a qualified Medical Practitioner or Health care professional through various mode of communication like audio, video, online portal, chat or mobile application. The services provided under this Benefit will be made available subject to the terms and conditions, and in the manner prescribed below:

- The Medical Practitioner may suggest/recommend/prescribe over the counter medications based on the information provided, if required on a case to case basis. However, the services under this Benefit should not be construed to constitute medical advice and/or substitute the Insured Person's visit/ consultation to an independent Medical Practitioner/Healthcare professional*.
- There shall be no maximum limit on the count of tele-consultations that can be availed by the Insured Person in a policy year
- This service will be available 24 hours a day, and 365 days in a year.
- We/Medical Practitioner/Healthcare professional may refer the Insured Person to another specialist or a general physician (outside of our empanelled network), if required and the charges for such specialist or a general physician will have to be borne by the Insured Person.
- We will provide Emergency assistance information such as nearest ambulance / hospital / blood bank etc.
- We shall not be liable for any discrepancy in the information provided under this Benefit.
- Choosing the services under this Benefit is purely upon the customer's own discretion and at own risk.
- *The proposer should seek assistance from a health care professional when interpreting and applying them to the Insured person's individual circumstances. If the Insured person has any concerns about His/ her health, He/ She may consult His/ her general practitioner. We shall not hold any responsibility towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner/ Healthcare professional

4.11 Home Care Treatment

We will cover the medical expenses incurred by the Insured Person on home care treatment maximum up to 5% of Sum Insured subject to a limit of Rs. 25,000 provided that:

a. The Medical Practitioner advices the Insured Person to undergo treatment at home
b. There is a continuous active line of treatment with monitoring of the health status by a medical practitioner for each day through the duration of the home care treatment.
c. Daily monitoring chart including records of the treatment duly signed by the treating doctor is maintained
d. The condition of the Insured Person is expected to improve in a reasonable and foreseeable period of time.
e. Treatment that can be availed on outpatient basis will not be qualified to be covered under this clause.
f. Prior approval from Us has been taken. The Home care treatment is availed only on a cashless basis, subject to availability of our empanelled service provider(s). Kindly visit our website for cities/locations where such services are available.
g. Treatment availed is not categorized under "AYUSH" or any form of non- allopathic treatment

However in case of unavailability of our empanelled service provider in the insured person's location, in case the insured person intends to avail the services of non-network provider and claims for reimbursement, a prior approval from Us needs to be taken before availing such services.

In case the insured person breaches the conditions of approval or fails to take the prior written approval from Us, we are not liable to settle any claim under this section.

For the purpose of this benefit, Home care treatment shall include:

a. Diagnostic tests underwent at home as advised by medical practitioner
b. Medicines prescribed in writing by a medical practitioner
c. Consultation charges of the medical practitioner
d. Nursing charges if advised by the medical practitioner

Any expenses payable during the Policy period shall not in aggregate exceed the Annual Sum Insured and Guaranteed Cumulative Bonus (if any) as specified in the Policy Schedule against this Benefit.

4.12 Sum Insured Protector

In consideration of payment of additional premium to Us, the insured person can avail the benefit under sum insured protector. The Sum Insured protector is designed to protect the Sum Insured against rising inflation by linking the Sum Insured under the base plan to the Consumer Price index (CPI).

The Sum Insured will be increased on cumulative basis at each renewal on the basis of inflation rate in previous\ year. Inflation rate would be computed as the average CPI of the entire calendar year published by the Central Statistical Organisation (CSO).

The % increase will be applicable only on Annual Sum Insured under the Policy and not on guaranteed cumulative bonus or any other benefit which leads to increase in Sum Insured.

Sample Illustration 1

*Considering Consumer Price index (CPI) of previous year to be 6%

Year	Annual Sum Insured	Opted for Sum Insured Protector	Sum Insured Protector at Renewal computation	Overall Sum Insured Protector
0	Rs. 10,00,000	Yes	Not applicable	Not applicable
1	Rs. 10,00,000	Yes	Rs. 10,00,000 * 6%	Rs. 60,000
2	Rs. 10,00,000	Yes	Rs. 10,00,000 * 6%	Rs. 60,000 + Rs. 60,000 = Rs. 1,20,000
3	Rs 10,00,000	Yes	Rs. 10,00,000 * 6%	Rs. 1,20,000 + Rs. 60,000 = Rs. 1,80,000
4	Rs. 10,00,000	No	Nil as Insured has opted out	Nil

Sample Illustration 2

Year	Annual Sum Insured	Opted for Sum Insured Protector	Sum Insured Protector at Renewal computation	Overall Sum Insured Protector
0	Rs. 10,00,000	Yes	Not applicable	Not applicable
1	Rs. 10,00,000	Yes	Rs. 10,00,000 * 6%	Rs. 60,000
2	Rs. 15,00,000	Yes	Rs. 10,00,000 * 6%	Rs. 60,000 + Rs. 60,000 = Rs. 1,20,000
3	Rs 15,00,000	Yes	Rs. 15,00,000 * 6%	Rs. 1,20,000 + Rs. 90,000 = Rs. 2,10,000
4	Rs. 15,00,000	No	Nil as Insured has opted out	Nil

Considering Consumer Price index (CPI) of previous year to be 6%

*Considering Insured has enhanced the Base Sum Insured to Rs.15,00,000 in the second renewal year

4.13 Claim Protector

In consideration of payment of additional premium to Us, the insured can avail the benefit as mentioned under claim protector. If a claim has been accepted under the inpatient hospitalization cover, then the items which are not payable under the claim as per the List of Excluded items released by IRDAI that is related to the particular claim will become payable. The maximum claim payout under this benefit shall be limited to Annual Sum Insured under your policy.

SECTION 5 – Waiting Periods and Survival Periods:

5.1: Waiting Period for PED:

This optional benefit allows the Insured / Insured Person to opt for 24/36/48 months of waiting period.

5.2: Waiting Period for Named Ailments:

This optional benefit. allows the Insured / Insured Person to opt for 24/12 months of waiting period. This named ailments are listed in **SECTION 7 - EXCLUSIONS: B. Exclusion Name: Specified disease/procedure waiting period- Code- Excl02**

5.3: Waiting period for Bariatric Surgery

This benefit can be availed after a waiting period of 3 years as per advice of Medical Practitioner

5.4: Waiting period for Critical Illness:

This optional benefit allows the Insured / Insured Person to opt for 60 / 90 days of waiting period.

5.5: Survival period for Critical Illness:
This optional benefit allows the Insured / Insured Person to opt for 30 days of survival period.

5.6: Co payment:
Co payment will be applicable as chosen by the Insured. This optional benefit allows the Insured to opt for 10% or 20% co-payment.

5.7 Waiting period for below illnessess

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Mental Illness specifically for the following ICD codes:

Schizophrenia (ICD - F20; F21; F25)

Bipolar Affective Disorders (ICD - F31; F34)

Depression (ICD - F32; F33)

Obsessive Compulsive Disorders (ICD - F42; F60.5)

Psychosis (ICD - F 22; F23; F28; F29)

The waiting period chosen for Pre-existing Diseases will by default apply to this section.

SECTION 6 – Wellness and Value Added Services:

This services will be available to all Insured / Insured persons and this will have no premium and / or Sum Insured impact.

6.1 Health Rewards

Insured can accumulate rewards by opting for an array of wellness programs listed below, that will help assess his/her health status and aid in improving the overall well-being.

There will be no limitation to the number of programs one can enroll however maximum rewards that all the insured person(s) in a single policy period can earn, will be limited to 5% in a year and of the policy premium for the opted tenure on renewal. The Wellness Rewards will get accrued in the following manner:

Wellness Grid HRA GRID		
Services	**Points**	**Limits**
Completes Health Risk Assessment	100	1 HRA

Does 2 Health Risk Assessment in a Year	200	Additional points
Basis Investigation Report (upload into our portal)		
Services	**Points**	**Limits**
Comprehensive health report (Routine Urine Analysis (RUA), Lipid profile, Compete Blood Count (CBC), Kidney Function Test (KFT), Liver Function Test (LFT), Hepatitis B Surface Antigen Test (HBsAg,)	1000	Max 1
2D Echocardiogram	300	Max 1
Magnetic Resonance Imaging (MRI Scan)	300	Max 1
Glycosylated Hemoglobin (Hb1Ac Report)	200	Max 1
Prostate Specific Antigen (PSA)	200	Max 1
Mammography	1000	Max 1
Bone Scan	1000	Max 1
Bone Densitometry test	1000	Max 1
Healthy Initiaitves		
Services	**Points**	**Limits**
Membership (Gym, Fitness Club, Yoga) for a year	3000	Max. 2
Participation in Walkathon, Marathon, Fitness League, Cycling, Swimming Competition	1000	Max 4
Claim		
Services	**Points**	**Limits**
Enrollment within 30 Days with our wellness portal for this additional points will be offered	1000	Max 1
Invoices should be uploaded within 60 days from the Date of Invoice date for points redemption		
Per Point Value-INR 0.30 Paise		

Any member in the policy can avail these facilities and accumulate the above reward points for both individual and floater policies.

The accrual shall happen on continuous coverage basis and if the insured fails to continue these activities in subsequent years or fails to redeem these discounts in the subsequent year/subsequent renewals, the accrual shall fall to zero and the insured will have to start the process again to achieve the maximum discount benefit.

Policy Premium means the premium paid by the proposer to the Company for the renewal policy period, post application of all discounts & loadings excluding any applicable taxes.

- The Total Accrual rewards earned as reward scale as percentage of the premium paid during the renewal year shall be converted to and accumulated as reward points as mentioned in the Wellness and Value Added Services.

- In case of Multi-year policies, the insured needs to perform all or any of the activities at least once during the tenure of the insurance.

- Rewards can be redeemed in the following manner

Adjustment of renewal year premium, when the insured purchases selected health insurance products from the company post accrual of the wellness rewards points under this policy. However, the total rewards points that can be utilized in a policy tenure shall not exceed 5% of the policy premium for such health policy.

- Rewards Points earned by an insured cannot be transferred to anyone or rewards points earned under multiple such programs cannot be clubbed together for redemption in any single policy.

HRA to be availed by login in on company's portal. All Invoices and reports to be uploaded on company's wellness portal to be elgible for redemption.

6.2 Medical Condition Management Program:

The insured will have a choice to avail various wellness benefits/services under this benefit head provided by the Company through the network of specialists/service providers. The assistance in arranging consultation will be provided on best effort basis. The cost of the services shall be borne by Insured / Insured Person.

1. Health Coach to monitor your day to day well being - The Insured Person will have the facility to connect with a personal coach to motivate the Insured person to achieve his/her personal health goals.

2. Chronic Condition Screening – Customized Health Checks including gene screening to understand the potential health risks the insured(s) may encounter in future or to avail regular screenings for chronic conditions to stay abreast about their on-going health and corrective/precautionary measures can be taken.

3. Condition Specific Care

a. Orthopedics Program (Rehabilitation and mobilization, Nursing attendant, Physiotherapist and medical equipments, etc.).

b. Oncology Program (Palliative care support, Stroma care, Colostomy, Tube feeding, Supportive care, etc.).

c. Pulmonary Program (Services/programs related to Improving breathing ability. Improving overall strength and exercise tolerance, programs to increase participation in daily physical and social activities)..

d. Diabetes Management Program (Services such as Personal Health Coach, Personal Nutritionist, Hypo/Hyper Alerts Management, etc may be availed on the basis of need or as recommended by the treating medical practitioner).

e. Internal Medicine Program (Services such as Doctor visits at home, Triage nursing, Medicine delivery, etc. may be availed on the basis of need or as recommended by the treating medical practitioner).

6.3 Video / Tele Consultation

Assistance in arranging consultation with a medical practitioner through Network Service Providers for assessing the medical records or routine health issues of the Insured Person over the phone or Video Chat on best effort basis. The cost of the services shall be borne by Insured / Insured Person.

6.4 Tele medicine

Assistance in arranging consultation with a medical practitioner through Network Service Providers to evaluate, diagnose and treat patients at a distance using telecommunications technology on best effort basis. Telemedicine involves the use of electronic communications and software to provide clinical services to patients without an in-person visit. The cost of the services shall be borne by Insured / Insured Person.

6.5 Pharmacy and Diagnostic Services

You may purchase medicines and diagnostic services from our Network Service Provider on best effort basis. The cost for the purchase of the medicines or diagnostic services shall be borne by Insured / Insured Person. Assistance in arranging delivery of purchased medicine on best effort basis

6.6 Online Chat with Doctor

The Insured / Insured person can get answers to their health problems by consulting a physician online via an online chat from our panel of doctors available through our network service provider. The cost of the services rendered by the medical practitioner shall be borne by Insured / Insured Person.

6.7 Doctor on Call:

The insured can avail the benefit of doctor on call according to the policy schedule. The insured can avail doctor consultation for any ailment or illness over call upto the limit specified in the schedule to the policy.

6.8 Health Assistance: We also provide Health Assistance as a part of Our Value added services, Our Health Assistance Team (HAT) will assist the Insured Person in understanding his/her health condition better by providing answers to any queries related to health and health care providers on Our dedicated helpline. To avail this service, the Insured Person may call Our helpline on 040-66274205 (please note that this number is subject to change).The services provided under this shall include:

- Identifying a Physician/ Specialist
- Scheduling an appointment with any Medical Practitioner empanelled with Us
- Scheduling appointments for a second opinion
- Providing suitable options with respect to Hospitals as well as providing assistance in Cashless facility, wherever applicable.
- Providing preventive information on ailments
- Providing guidance on post Hospitalization care, such as Physiotherapy/ Nursing at home.
- The list of the Service Providers is available at our website (https://www.icicilombard.com/content/ilom-en/serviceprovider/search.asp) and is subject to amendment from time to time.

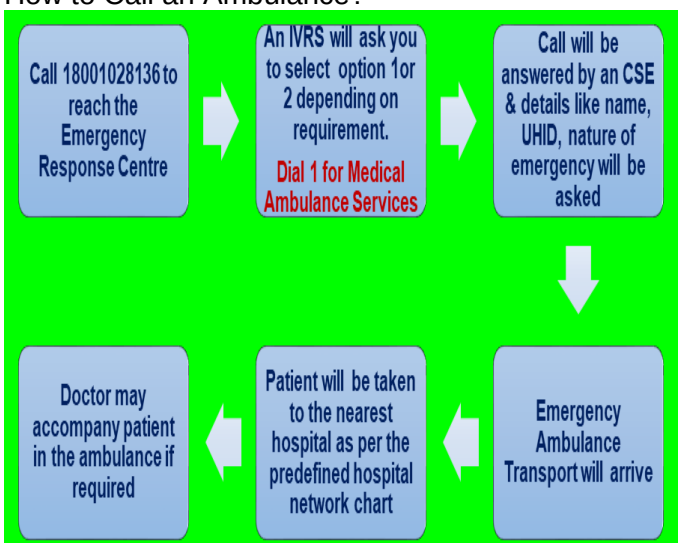
6.9 Ambulance Assistance

We will facilitate ground medical transportation by a Service provider to transport the Insured Person to the nearest Hospital or any clinic or nursing home for medically necessary treatment subject to availability of services in that particular city/location. Kindly visit our website for updated list of cities/locations where the services are provided.

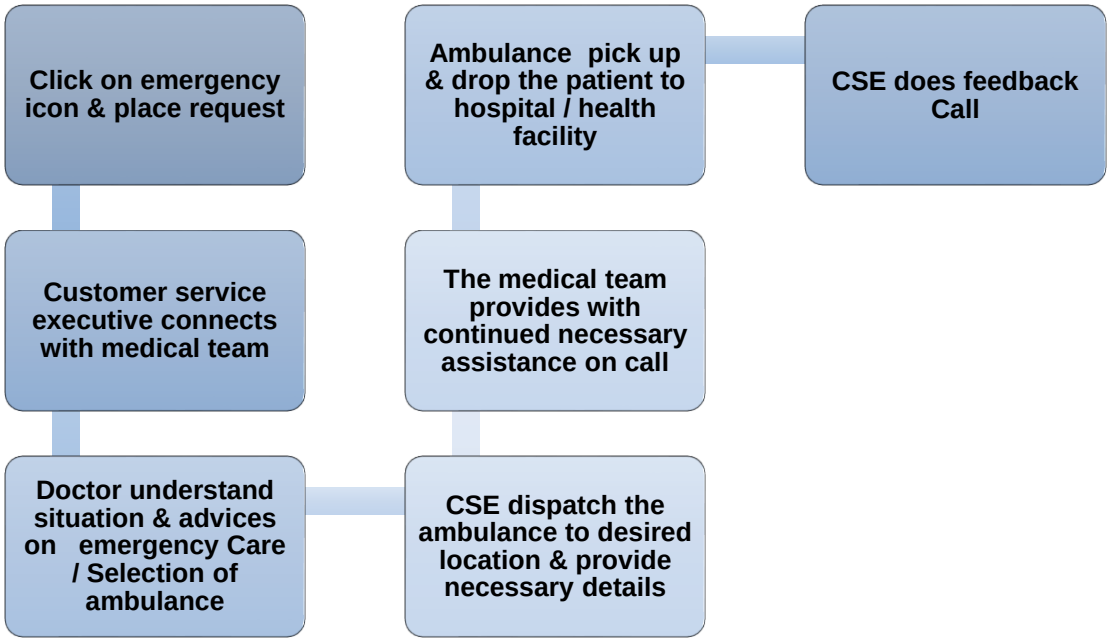
1. The services under this Benefit are subject to the following conditions:
   - The medical transportation is for a life threatening health condition of the Insured Person which requires immediate and rapid transportation to the Hospital; as certified in writing by the Medical practitioner
   - The Insured Person is in India and the treatment is in India only;
   - The ambulance service is availed within the same city
   - This is an assistance service and the expenses for the same will have to be borne by the insured person or can be claimed under surface ambulance cover(if inpatient treatment claim is found to be admissible)
2. Process to avail Ambulance Assistance:
   a. On calling Our helpline number provided below, Our trained customer service executive (CSE) will ask the Insured person relevant questions to assess the situation.

b. The call may be redirected to a qualified Medical Practitioner in order to evaluate the requirement for an ambulance with Advanced Life Support based on the Insured Person's condition.
c. The below mentioned details are to be made available for availing the services:
   1. UHID of Insured Person, as provided on the Health Card.
   2. Contact number of the Insured Person
   3. Location of Insured Person

How to Call an Ambulance?



How to Call an Ambulance? (Via Mobile Application)



6.10 Discounts on services/products

We shall only facilitate the Insured Person in availing discounts on services/products including but not limited to investigations/diagnostic tests/ laboratory tests /health supplements/ /medical equipment/homecare services/virtual health & wellness sessions/AYUSH products/Fitness & wellness related activities & products etc. at our empanelled diagnostic centres, drugs/medicines ordered from pharmacies etc. offered by our network providers/ health service providers. These discounts can be viewed on our mobile application and one can redeem the wellness points earned from Health rewards for availing discounts as per product terms and conditions and subject to availability.

The above benefits will be subject to following conditions:

- For services that are availed over phone or through online/digital mode, the Insured / Insured Person will be required to provide the details as sought by our Service Provider in order to establish authenticity and validity prior to availing such services.
- It is entirely for the Insured / Insured Person to decide whether to obtain these services, the extent to which he/she wishes to avail these services and further to decide whether to use any of these services and if so to which extent.
- The services are intended to provide support information to the Insured Person to improve well-being and habits through working towards personalized health goals. These services are not medical advice and are not meant to substitute the Insured / Insured Person's visit/ consultation to an independent Medical Practitioner.
- The information services provided under these benefits, including information provided through personalized health coaching services, does not constitute medical advice of any kind and it is not intended to be, and should not be, used to diagnose or identify treatment for a medical condition.
- The Insured Person shall be free to consider or not consider the suggestions of the health coach and make any lifestyle changes based on information provided through these services. For any change the Insured Person makes to his lifestyle whether or not on the advice of the health coach, we shall in no manner be liable for any harm or injury, whether bodily or otherwise that may occur as a result of such lifestyle changes. The Insured Person must seek immediate medical advice if there is any adverse effect or discomfort on making any lifestyle changes.
- The company shall not be liable for any damages sustained by the Insured Person on such information or suggestions provided by Health Coach or any of the service rendered by our service provider.
- The company is not responsible for any medical or mental health problems the Insured Person may face as a result of accessing or using these services.
- The Insured Person is solely responsible for all information, data, text, music, sound, photographs, graphics, video, messages or other materials that the Insured Person uploads, transmits, posts, publishes or displays on any platform used by the service providers
- The Insured Person expressly understands and agrees that we will not be liable for any damages related to services provided by the network service provider
- The cost of the services rendered by the medical practitioner shall be borne by Insured / Insured Person.

e. SECTION 7 - EXCLUSIONS:

i. Standard Exclusions (Exclusions for which standard wordings are specified by IRDAI)

A Pre-Existing Diseases - Code- Excl01

a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48/36/24 months of continuous coverage after the date of inception of the first policy with insurer as selected by the Insurer.
b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c. If the Insured Person is continuously covered without any break as defined under the portability / migration norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
d. Coverage under the policy after the expiry of 48/36/24 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

B. Specified disease/procedure waiting period- Code- Excl02

a. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24/12 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

f. List of specific diseases/procedures

1. Any types of gastric or duodenal ulcers
2. Benign prostatic hypertrophy
3. All types of sinuses
4. Hemorrhoids
5. Dysfunctional uterine bleeding
6. Endometriosis

7. Stones in the urinary and biliary systems

8. Surgery on ears/tonsils/adenoids/ paranasal sinuses

9. Cataracts,

10. Hernia of all types and Hydrocele

11. Fistulae in anus

12. Fissure in anus

13. Fibromyoma

14. Hysterectomy

15. Surgery for any skin ailment

16. Surgery on all internal or external tumours/ cysts/ nodules/polyps of any kind including breast lumps with exception of Malignancy

17. Dialysis required for Chronic Renal Failure.

18. Joint Replacement Surgeries unless necessitated by Accident happening after the Policy risk inception date.

19. Dilatation and curettage

20. Varicose Veins and Varicose Ulcers

21. Non Infective Arthritis and other form arthritis

22) Gout and Rheumatism

23) Prolapse inter Vertebral Disc and Spinal Diseases including spondylitis/spondylosis unless arising from Accident

C. 30-day waiting period- Code- Excl03

a) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

b) This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

D. Investigation & Evaluation- Code- Excl04

a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.

b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

E.: Rest Cure, rehabilitation and respite care- Code- Excl05

a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

F. Obesity/ Weight Control: Code- Excl06

1. Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
2. Surgery to be conducted is upon the advice of the Doctor
3. The surgery/Procedure conducted should be supported by clinical protocols
4. The member has to be 18 years of age or older and
5. Body Mass Index (BMI);
   a. greater than or equal to 40 or
   b. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
      i. Obesity-related cardiomyopathy
      ii. Coronary heart disease
      iii. Severe Sleep Apnea
      iv. Uncontrolled Type2 Diabetes

G. Change-of-Gender treatments: Code- Excl07

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

H. Cosmetic or plastic Surgery: Code- Excl08

Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

I. Hazardous or Adventure sports: Code- Excl09

Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

J. Breach of law: Code- Excl10

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

K. Excluded providers: Code- Excl 11

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

L. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and

consequences thereof. **Code- Excl 12**

M. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons.**Code- Excl13**

N. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure. **Code- Excl14**

O. Refractive Error: Code- Excl15

Expenses related to the treatment for correction of eye sight due to refractive error less than 7. 5 dioptres.

P. Unproven Treatments: Code- Exel 16

Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

Q. Sterility and Infertility: Code- Excl 17

Expenses related to sterility and infertility. This includes:

a. Any type of contraception, sterilization
b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
c. Gestational Surrogacy
d. Reversal of sterilization

R. Maternity: Code Excl18

i. Medical treatment expenses traceable to childbirth (including complicated

deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;

ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

This exclusion will stand modified to the effect to cover **4.2: Maternity Cover**

ii. Specific Exclusions (Exclusions other than those specified under e. i. above)

S. War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

T. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

a) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.

b) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

c) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

U. Any expenses incurred on OPD treatment. This exclusion will stand modified to the effect to cover **Section 4.5: OPD for Medical and Dental**

V. Treatment taken outside the geographical limits of India. This exclusion will stand modified to the effect to cover Section 4.9: Worldwide cover

W. Any ailment/ illness/ injury/ condition or treatment or service that is specifically excluded in the Policy Schedule under Special Conditions.

f. SECTION 8- GENERAL CONDITIONS:

I. Standard General Terms and clauses (General terms and clauses whose wordings are specified by IRDAI)

1. Disclosure of Information:

The policy shall be Void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.

(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

2. Condition Precedent to Admission of Liability:

The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

3. Claim Settlement (provision for Penal Interest)

i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.

ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases,

the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

4. Fraud:

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;
b) the active concealment of a fact by the insured person having knowledge or belief of the fact;
c) any other act fitted to deceivee; and
d) any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

5. Multiple policies

i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.

iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.

iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

6. Free Look Period:

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.

The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or

ii. Where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or

iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

7. Cancellation:

The policyholder may cancel this policy by giving l5days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

1 year Policy

Months Expired	Premium Retained
0-3	25%
3-6	50.0%
6-9	75.0%
9-12	100.0%

2 year Policy

Months Expired	Premium Retained
0-3	15%
3-6	25%
6-9	50%
9-12	65%
12-15	75%
15-18	85%
18-24	100%

3 year Policy

Months Expired	Premium Retained
0-3	15%
3-6	25%
6-9	35%
9-12	40%
12-15	50%
15-18	60%
18-21	70%
21-24	80%
24-27	85%
27-30	90%
31-36	100%

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

8. Renewal of Policy:

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.

ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.

iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period

iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.

v. No loading shall apply on renewals based on individual claims experience.

9. Premium payment in instalments:

If the insured person has opted for Payment of Premium on an installment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in Your Policy Schedule, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy)

i. For Yearly and single payment of mode, a fixed period of 30 days is to be allowed as GracePeriod and for all other modes of payment a fixed period of 15 days be allowed as grace period.
ii. During such grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.
iii. The insured person will get the accrued continuity benefit in respect of the ' Waiting Periods' , 'Specific Waiting Periods' in the event of payment of premium within the stipulated grace Period
iv. No interest will be charged If the installment premium is not paid on due date.
v. In case of installment premium due not received within the grace Period, the Policy will getcancelled.
vi. In the event of a claim, all subsequent premium instalments shall immediately become

due andpayable

vii. The company has the right to recover and deduct all the pending installments from the claimamount due under the policy.

10. Portability

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

For Detailed Guidelines on portability, kindly refer the link
https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

11. Migration

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy atleast 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

For Detailed Guidelines on migration, kindly refer the link
https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

12. Withdrawal of Policy

In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.

Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

13. Moratorium Period

After completion of eight continuous years under the policy no look back to be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

14. Possibility of Revision of Terms of the Policy Including the Premium Rates

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected.

15. Nomination

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the policyholder. the Company will pay the nominee (as named in the Policy Schedule/Policy Certificate/Endorsement (if any)) and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

16. Grievance Redressal Procedure:

In case of any grievance the insured person may contact the company through

Website: www.icicilombard.com

Toll Free: 1800 2666

E-Mail: customersupport@icicilombard.com

Courier: ICICI Lombard General Insurance Company Ltd.

ICICI Lombard House,

414, P Balu Marg, Off Veer Savarkar Road,

Nr Siddhi Vinayak Temple,

Prabhadevi, Mumbai 400025

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance

If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at Manager- Service Quality,

Corporate Manager- Service Quality, National Manager- Operations & finally Director-services and Business development at the following address:

ICICI Lombard General Insurance Company Limited,

ICICI Lombard House,

414, P Balu Marg, Off Veer Savarkar Road,

Nr Siddhi Vinayak Temple,Prabhadevi, Mumbai 400025

For updated details of grievance officer, kindly refer the link

https://www.icicilombard.com/grievance-redressal.com

If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.

Grievance may also be lodged at IRDAI Integrated Grievance Management System - https://www.irdai.gov.in/ADMINCMS/cms/NormalData_Layout.aspx?page=PageNo225&mid=14.2

LIST OF INSURANCE OMBUDSMEN

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The contact details of the **Insurance Ombudsman** offices are as below. These details can also be found at http://www.cioins.co.in/ombudsman.html.

Office Details	Jurisdiction of Office Union Territory, District)
AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
BHOPAL Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh Chhattisgarh.
BHUBANESHWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa.
CHANDIGARH Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Tamil Nadu Puducherry Town and Karaikal (which are part of Puducherry).

DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
ERNAKULAM Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti,

Fax: 0522 - 2231310 Email: bimalokpal.lucknow@cioins.co.in	Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
PUNE Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

17. Complete Discharge

Any payment to the policyholder, insured person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

II. Specific terms and clauses (terms and other clauses other than those mentioned under f.i above)

18. Floater Policy:

Where the Policy is obtained on floater basis covering the family members, the Sum Insured as specified in the Schedule to this Policy, shall be available to the Insured and all other Insured Persons. However, the Sum Insured shall be the overall limit including Optional Sum Insured unless otherwise specified, if opted and guaranteed GCB, if any for the entire period of Insurance/Policy period including all members/Insured persons and all claims.

19. Material Change:

The Insured / Insured Person shall immediately notify the Company in writing of any material change in the risk on account of change in nature of occupation or business, partial disclosure of the medical history at Insured / Insured person own expense. The Company may, adjust the scope of cover and / or the premium, if necessary, accordingly.

20. No Constructive Notice:

The Company shall not take notice of any information relating to the Insured person unless such information is submitted in writing by the Insured, even if such information was available with the Company.

21. Notice of Charge:

The Company is not under obligation to take note of any trust, assignment, lien or similar charge on or relating to the Policy. However, any payment by the Company to Insured or legal representative or bank shall be binding on all concerned and shall be considered as complete discharge by the Company.

22. Special Provisions:

Any special provisions subject to which this Policy has been entered into and endorsed on the Policy or in any separate instrument shall be deemed to be part of this Policy and shall have effect accordingly.

23. Electronic Transaction:

The Insured / Insured Person agrees to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time and hereby agrees and confirm that all transactions effected by or through facilities for conducting remote transactions including the internet, world wide web, electronic data interchange, call centres, tele service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication established by or on behalf of the Company for and in respect of the Policy or its terms, shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time. However, the terms of this condition shall not override provisions of any law(s) or statutory regulations including provisions of IRDA regulations for protection of Policy holder's interests.

24. Duty of the Insured on occurrence of loss/event leading to claim

On the occurrence of loss/event/claim within the scope of cover under the Policy resulting in a claim, the Insured / Insured Person shall:

a. Forthwith file/submit a claim form in accordance with "Claim Procedure" clause.
b. Allow the Medical Practitioner or any agent of the Company to inspect the medical and hospitalization records and to examine the Insured / Insured Person
c. Assist and not hinder or prevent the Company or any of its agents in pursuance of their duties

In case the Insured / Insured Person does not comply with the provisions of this clause or other obligations cast upon the Insured / Insured Person under this Policy or in any of the Policy documents, all benefit under the Policy shall be forfeited, at the option of the Company.

25. Right to Inspect:

If required by the Company, an agent/representative of the Company including a physician appointed in that behalf in case of any loss/event/claim or any circumstances that have given rise to a claim to the Insured / Insured Person, be permitted at all reasonable times to examine into the circumstances of such loss/event leading to claim. The Insured / Insured Person shall on being required so to do by the Company produce all relevant documents relating to or containing reference relating to the loss/event or such circumstance in his/her possession including presenting himself/herself for examination and furnish copies of or extracts from such of them as may be required by the Company so far as they relate to such claims or shall assist the Company to ascertain the correctness thereof or the liability of the Company under this Policy.

The Company shall bear all cost of examination required under this section.

26. Position after a claim:

As from the day of receipt of the claim amount by the Insured / Insured Person, the Sum Insured for the remainder of the Policy year of insurance shall stand reduced by a corresponding amount.

27. Forfeiture of claims:

If any claim is made and rejected and no court action or suit is commenced within 12 months after such rejection or, in case of arbitration taking place as provided therein, within 12 calendar months after the arbitrator or arbitrators have made their award, all benefits under this Policy shall be forfeited and will not have any rights whatsoever.

28. Cause of action/Currency of payment:

No claim shall be payable under this Policy unless the cause of action arises in India. All claims shall be payable in India in Indian Rupees only.

29. Policy Disputes:

The parties to this Policy expressly agree that the laws of the Republic of India shall govern the validity, construction, interpretation and effect of this Policy. Any dispute concerning the interpretation of the terms and conditions, limitations and/or exclusions contained herein is understood and agreed to by both the Insured and the Company to be subject to Indian law. All matters arising hereunder shall be determined in accordance with the law and practice of such court with in Indian Territory.

30. Arbitration:

If any dispute or difference shall arise as to the quantum to be paid under this Policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties to the dispute/difference, or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of 3 arbitrators, comprising of 2 arbitrators - 1 to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such 2 arbitrators.

Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996.

It is hereby agreed and understood that no dispute or difference shall be referred to arbitration, as herein before provided, if the Company has disputed or not accepted liability under or in respect of this Policy.

It is expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this Policy that the award by such arbitrator/arbitrators of the amount of the loss shall be first obtained.

31. Sum Insured Enhancement:

i. The Insured member can apply for enhancement of Sum Insured at the time of renewal by submitting a duly filled fresh Proposal Form to the Company.
ii. The acceptance of enhancement of Sum Insured would be at the discretion of the Company, based on the health condition of the Insured members, claim history and subject to acceptance by the Company post underwriting.

All waiting periods as defined in the Policy shall apply afresh for this enhanced Sum Insured from the effective date of enhancement of such Sum Insured considering such Policy Period as the first Policy in respect of such increased Sum Insured.

32. Policy alignment

Policy Alignment option will be available in cases wherein insured(s) with two separate health indemnity policies with Us, having different policy end dates but want to align the policy start dates. We can align the policies by extending the coverage of one policy till the end date of the other policy.

Such policies will be charged with premium on pro rata basis though the sum insured under the policy shall remain constant.

33. Endorsements (Changes in Policy)

i. This policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the company. Any change made by the company shall be evidenced by a written endorsement signed and stamped.
ii. The proposer may be changed only at the time of renewal. The new proposer must be the legal heir/immediate family member. Such change would be subject to acceptance by the company and payment of premium (if any). The renewed Policy shall be treated as having been renewed without break.
iii. The proposer may be changed during the Policy Period only in case of his/her demise or him/her moving out of India.
iv. Mid- term endorsement of addition of member in the policy shall only be allowed for newly wedded spouse by marriage and new born baby with relevant documentation

34. Notices:

Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post or facsimile to

a) In case of the Insured, at the address given in the Schedule to the Policy.

b) In case of the Company, to the Policy issuing office/nearest office of the Company.

g. Other Terms and Conditions

Claim Administration

The fulfilment of the terms and conditions of this Policy (including payment of premium by the due dates mentioned in the Policy Schedule) insofar as they relate to anything to be done or complied with by each of You shall be conditions precedent to admission of Our liability. You are requested to go through our list of de-listed/excluded providers which is available on our website. As the list is dynamic, please refer to the latest list.

Further, upon the discovery or happening of any Illness or Injury that may give rise to a Claim under this Policy, then as a condition precedent to the admission of Our liability, You shall undertake the following

1.1 Claims Procedure

A. For Cashless Settlement

Cashless treatment is only available at a Network Provider (List of Network Providers is available at our website). In order to avail of cashless treatment, the following procedure must be followed by You:

Pre-authorization

Prior to taking treatment and/ or incurring Medical Expenses at a Network Provider, You must contact Us or Our in house claim processing team accompanied with full particulars namely, Policy Number, Your name, Your relationship with Policy Holder, nature of Illness or Injury, name and address of the Medical Practitioner/ Hospital and any other information that may be relevant to the Illness/ Injury/ Hospitalisation. You must request preauthorization at least 48 hours before a planned Hospitalization and in case of an emergency situation, within 24 hours of Hospitalization. To avail of Cashless Hospitalization facility, you are required to produce the health card, as provided to You with this Policy, subject to the terms and conditions for the usage of the said health card Or You can seek pre authorization by providing Your Policy number and ID proof to the hospital who can co-ordinate with Our claim team to provide cashless facility. We will consider Your request after having obtained accurate and complete information for the Illness or Injury for which cashless Hospitalization facility is sought by You and We will confirm Your request in writing.

B. For Reimbursement Settlement

You shall give notice to Us or Our in house claim processing team by calling the toll free number 1800 2666 or emailing us at customersupport@icicilombard.com as specified in the Policy provided to You and also in writing at Our address with particulars as below:

Policy number;

Your Name;

Your relationship with the Policyholder;

Nature of Illness or Injury;

Name and address of the attending Medical Practitioner and the Hospital;

Any other information that may be relevant to the Illness/ Injury/ Hospitalisation

The above information needs to be provided to Us or Our in house claim processing team immediately and in any event within 10 days of Hospitalization, failing which We will have the right to treat the Claim as inadmissible, as We may deem fit at Our sole discretion.

You must immediately consult a Medical Practitioner and follow the advice and treatment that he recommends.

You or someone claiming on Your behalf must promptly and in any event within 30 days of Your discharge from a Hospital (for post-hospitalization expenses, within 30 days from the completion of post-hospitalization period) deliver to Us the documentation (written details of the quantum of any Claim along with all original supporting documentation) as more particularly listed in Claim documents section. In case there is a delay beyond 30 days in submission of claim documents, we may condone the delay provided the insured person submits a valid reason justifying the delay to us in writing. However, in both the above cases i.e. g. 1.1.1(A) & (B), You must take reasonable steps or measure to minimise the quantum of any Claim that may be covered under the Policy If so requested by Us or Our in house claim processing team, You will have to undergo a medical examination from Our nominated Medical Practitioner, as and when We or Our in house claim processing team considers reasonable and necessary. The cost of such examination will be borne by Us

Claim falling in two Policy periods

If the claim event falls within two Policy periods, the claims shall be paid taking into consideration the available Sum Insured in the two Policy periods, including the Deductions for each Policy Period. Such eligible claim amount to be payable to the Insured shall be reduced to the extent of premium to be received for the Renewal/due date of premium of health insurance Policy, if not received earlier.

1.2 CLAIM DOCUMENTS

You shall be required to furnish the following documents for or in support of a Claim:

1. Duly completed Claim form signed by You and the Medical Practitioner. The claim form can be downloaded from our website www.icicilombard.com
2. Original bills, receipts and discharge certificate/ card from the Hospital/ Medical Practitioner
3. Original bills from chemists supported by proper prescription.
4. Original investigation test reports and payment receipts.

5. Indoor case papers
6. Medical Practitioner's referral letter advising Hospitalization in non-Accident cases.
7. Any other document as required by Us or Our TPA to investigate the Claim or Our obligation to make payment for it

1.3 Claim Service Guarantee

We provide You Claim Service Guarantee as follows

A. For Reimbursement Claims: We shall make the payment of admissible claim (as per terms & conditions of Policy) OR communicate non admissibility of claim within 14 days after You submit complete set of documents & information in respect of the claims. In case We fail to make the payment of admissible claims or to communicate non admissibility of claim within the time period, We shall pay 2% interest over and above the rate defined as per IRDAI (Protection of Policyholder's interest) Regulation 2017.
B. For Cashless Claims: If You notify pre authorization request for cashless facility through any of Our empanelled network hospitals along with complete set of documents & information, We will respond within 2 hours of the actual receipt of such pre authorization request with:

Approval, or

Rejection, or

Query seeking further information

In case the request is for enhancement, i.e. Request for increase in the amount already authorized, We will respond to it within 2 hours.

In case of delay in response by Us beyond the time period as stated above for cashless claims, We shall be liable to pay ₹1,000 to You. Our maximum liability in respect of a single hospitalization shall, at no time exceed ₹1,000. We will not be liable to make any payments under this Claim Service Guarantee in case of any force majeure, natural event or manmade disturbance which impedes Our inability to make a decision or to communicate such decisions to You.

The service guarantee shall not be applicable for any cases delayed on account of reasonable apprehension of fraud or fraudulent claims or cases referred to/by any adjudicative forum for necessary disposal.

You may lodge claim separately for the hospitalization claim, Pre-Post hospitalization. In such scenario, if delay happens beyond the time period as specified above, the interest amount calculated will be on the net sanctioned amount of respective transaction and not the total amount paid for the entire claim.

Any amounts paid towards interest under Claim Service Guarantee will not affect the Annual Sum Insured as specified in the Schedule.

If you are not eligible for 'Claim Service Guarantee' for the reasons stated above, We will inform the same to You, within 14 days in case of A. For Reimbursement claims and within 2 hours in case of B. For Cashless claims above.

Annexure II :- List I- Items for which coverage is not available in the Policy

Sl No	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER

42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

List II- Items that are to be subsumed into Room Charges

SI No	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN

10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEX I MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKETS/VARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

List III — Items that are to be subsumed into Procedure Charges

Sl No.	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT

15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

List IV — Items that are to be subsumed into costs of treatment

Sl No.	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP— COST
8	HYDROGEN PEROXIDE\SPIRITS DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	Glucometer& Strips
18	URINE BAG

Policy Wordings – BeFit

Contents

b) PREAMBLE

This BeFit Rider is a contract of insurance between the Policyholder and Us subject to the receipt of applicable premium in advance with respect to the Insured Person(s).

It is agreed and understood that the BeFit Rider can only be bought along with the Base Product and cannot be bought in isolation or as a separate product. The BeFit Rider is subject to the terms and conditions stated below and also the Policy terms, conditions, exclusions and applicable endorsements of the Base Product.

c) DEFINITIONS

The terms defined in the Base Product and at other junctures in the Policy Wording have the meaning ascribed to them wherever they appear in this BeFit Rider and, where appropriate, references to the singular include references to the plural; references to the male include the female and third gender and references to any statutory enactment include subsequent changes to the same. All terms are subject to the terms defined in the Base Product and additional terms defined below:

ii. Specific Definition (Definitions other than those defined by IRDAI)

Age means the completed years of the Insured Person(s) on their last birthday as per the English calendar

AYUSH medical practitioner means a medical practitioner who is specialised in prescribing AYUSH treatment

Base Product means any retail health Insurance policy issued by ICICI Lombard General Insurance Company Limited including its terms and conditions, any annexure thereto and the Policy Schedule (as amended from time to time), the information statements in the proposal form and the Policy wording (including endorsements, if any) and to which this BeFit Rider is attached.

Cancellation defines the terms on which the policy contract can be terminated either by the insurer or the insured while giving sufficient notice to the other which is not lower than a period of fifteen days. The terms of cancellation may differ from insurer to insurer.

Health Service Provider means any person or entity providing healthcare and medical services in individual capacity, or through aggregation under “Health Service Provider Agreement”, and shall include but not be limited to any clinic, diagnostic centre, pharmacy, associated facility for diagnosis, treatment or wellness services, and health care providers empanelled with Us to provide services specified under the Benefits to the Insured Person on cashless basis for OPD Treatment or otherwise. The list of the Health Service Providers is available on our mobile application and is subject to amendment from time to time

Insured Person(s) means the individual(s) whose name(s) is/are specifically appearing as such in the Policy Schedule.

Life threatening refers to a medical condition suffered by the Insured Person which has the following characteristics:

- Markedly unstable vital parameters (blood pressure, pulse, temperature and respiratory rate).
- Acute impairment of one or more vital organ systems (involving brain, heart, lungs, Liver, Kidneys and pancreas)
- Critical care being provided, which involves high complexity decision making to assess, manipulate and support vital system function(s) to treat single or multiple vital organ failure(s) and requires interpretation of multiple physiological parameters and application of advanced technology.
- Critical care being provided in critical care area such as coronary care unit, intensive care unit, respiratory care unit, or the emergency department.

Medical Practitioner means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license.
The term Medical Practitioner would include general medical practitioner, specialist, super specialist, anaesthetist and surgeon but would exclude The Insured person and the Insured person's Immediate Family. "Immediate Family" would comprise of the Insured person's spouse, children, brother(s), sister(s), parent(s) and grandchildren.
Pathology means laboratory testing blood and other bodily fluids, tissues, and microscopic evaluation of individual cells.
Physiotherapy means the branch of medicine that deals with assessment, planning and implementation of rehabilitation programs that improve or restore human motor functions, maximize movement ability, relieve pain syndromes, and treat or prevent physical challenges associated with injuries, diseases and other impairments by applying a broad range of physical therapies and techniques such as movement, ultrasound, heating, laser and other techniques.
Policy Schedule means the Policy Schedule attached to and forming part of the Policy.
Psychologist is a person who specializes in the study of mind and behaviour or in the treatment of mental, emotional, and behavioural disorders
Radiology means the branch of medicine that deals with diagnostic images of anatomic structures through the use of electromagnetic radiation or sound waves and that treats disease through the use of radioactive compounds. Radiologic imaging techniques include but are not limited to x-rays, CAT scans, PET scans, MRIs, and ultra-sonograms.
Specialist/Super Specialist Medical Practitioner means a medical practitioner having additional expertise in any one or more types of medicine, including but not limited to, cardiology, diabetology, endocrinology, ENT, gastroenterology, general surgery, gynecology /obstetrics, internal medicine, nephrology, neurology, ophthalmology, orthopedics, pediatrics, psychiatry, urology, dermatology and pulmonology.
We/ Our/ Us/Insurer means the ICICI Lombard General Insurance Company Limited.

d) BENEFITS COVERED UNDER THE RIDER

The Benefits listed below are in-built benefits and shall be available to all Insured Persons in accordance with the procedures set out in this Policy wording.

All Benefits under the BeFit Rider can be availed only on cashless basis via our mobile application and are subject to the terms, conditions, waiting periods and exclusions of the Rider and the availability of the Annual sum insured.

All services shall be provided through our Empaneled Health Service Provider subject to availability at the time of appointment

Any unutilized consultations/e- consultations/ annual sum insured/ sessions cannot be carried forward to the next policy year.

Choosing the services under this BeFit Rider is purely upon the Insured Person's own discretion and at own risk. The services provided under the various covers are via third party health service providers/ network providers/ and the Insurer is not responsible for liability arising out of the services provided by these third parties.

The Insured Person(s) should seek assistance from a medical practitioner should they still have any concerns about their health even post availing services from our health service providers/network providers.

All claims under this Section shall be paid in accordance with the procedure set out in Section IV (Claim Procedure).

1. Outpatient Consultations

We shall cover the Medical Expenses incurred during the Policy period for out-patient consultations from a General Medical Practitioner or Specialist Medical Practitioner or Super Specialist Medical practitioner or AYUSH medical practitioner in relation to any Illness contracted or Injury suffered by the Insured Person during the Policy period subject to the overall maximum number of consultations as specified against this benefit in the policy schedule. These services shall be provided through our Empaneled Health Service Provider subject to availability at the time of appointment.

This benefit shall also include e-consultation given by a General Medical Practitioner or Specialist or Super Specialist Medical Practitioner or AYUSH medical practitioner through a virtual mode of communication such as but not limited to chat, email, video, online portal, or mobile application.

Physiotherapy sessions and counselling availed for psychiatric ailments or mental health issues shall be excluded from the scope of this benefit.

2. Routine Diagnostic Cover and Minor Procedure Cover

We shall cover medical expenses incurred for outpatient diagnostic tests recommended by Medical Practitioner under our cashless network available in the mobile application in relation to any Illness contracted or Injury suffered by the Insured Person during the Policy Period and for listed minor procedures undergone at a general practitioner or specialist/super-specialist medical practitioner by the Insured Person during the Policy period maximum up to the Annual sum insured limit as specified against this benefit in the policy schedule. These services shall be provided through our Empaneled Health Service Provider subject to availability at the time of appointment

The diagnostic tests shall include but will not be limited to histopathology, biochemistry, hematology, immunology, microbiology, serology, pathology, radiology, ultrasound and TMT. Genetic studies shall be excluded from the scope of this cover.

We may even arrange for diagnostic tests to be carried out at the location of the Insured Person provided such location is within the geographical reach of the Health Service Provider on the date of the request. This service shall be subject to availability of Our empanelled Health Service provider.

List of Minor Procedures covered under this benefit #

Drainage of abscess
Injection including Intramuscular (Per Injection cost)
Intravenous injection(IV)
Sprain Management (Joint movement/exercise)

Otoscopic examination (Magnifying otoscopy)
Nasal packing for control of haemorrhage
Nebulizer therapy
Removal of foreign body
Suturing(Staple under LA)
Removal of suture
Stabilization of joint
Syringing ear to remove wax
Application or removal of plaster cast
Laryngoscopy
Minor wound management

#this includes only the cost of administration. The actual cost of consumables shall be covered under the pharmacy cover. However, the said cost will have to be borne by the insured person in case the annual sum insured under the pharmacy cover has been exhausted or is out of scope of the Pharmacy cover or in case the consumable is a non-payable item as per the Base Product

3. Pharmacy Cover

We shall cover medical expenses incurred on purchase of medicines, drugs, and medical consumables, as prescribed by a Medical Practitioner under our cashless network available in the mobile application for any Illness contracted or Injury suffered by the Insured Person during the Policy Period, maximum up to the Annual sum insured limit as specified against this benefit in the policy schedule through our Empaneled Health Service Provider subject to availability on the date of the request.

Health supplements, Nutraceuticals, foods for special dietary use, foods for special medical purpose, foods with added probiotics and/or foods with added prebiotics, vaccinations, vitamins, tonics or other related products are excluded from the scope of this cover

4. Physiotherapy Session

We shall cover medical expenses incurred by the Insured person for physiotherapy sessions with a qualified physiotherapist to treat Illness, injury or deformity suffered as advised by qualified medical practitioners during the policy period by physical methods such as but not limited to massage, heat treatment, ultrasound, Laser and exercises maximum up to the number of visits sessions as specified against this benefit in the policy schedule.

These services shall be provided through our Empaneled Health Service Provider subject to availability at the time of appointment.

The time duration of each physiotherapy session shall be restricted to thirty minutes only.

5. Tele -Consultation

We shall cover medical expenses incurred by the Insured Person for any telephonic/ virtual consultations and recommendations for any Injury sustained or Illness contracted during the Policy period by a Medical Practitioner or health care professional. For the purpose of this benefit Telephonic/Virtual consultation shall mean consultation provided by a Medical Practitioner or Health care professional through various mode of communication like audio, video, online portal, chat or mobile application. The services provided under this Benefit shall be made available through our Empaneled Health Service Provider subject to the terms and conditions, and in the manner prescribed below:

- The Medical Practitioner may suggest/recommend/prescribe over the counter medications based on the information provided, if required on a case to case basis. However, the services under this Benefit should not be construed to constitute medical advice and/or substitute the Insured Person's visit/ consultation to an independent Medical Practitioner/Healthcare professional.
- This service shall be available 24 hours a day, and 365 days in a year.
- We/Medical Practitioner/Healthcare professional may refer the Insured Person to a specialist medical practitioner or a general physician, if required
- We shall not be liable for any discrepancy in the information provided under this Benefit.

6. e-Counseling

We shall cover expenses incurred by the Insured Person on e-counseling session(s) with a Psychologist via our mobile application for providing assistance in dealing with issues such as but not limited to personal and lifestyle imbalance, pre-marital counselling, parenting and child care, speech impairment, and problems related to psychological/mental illness/ psychiatric and psychosomatic disorders, stress, anxiety maximum up to the number of sessions as specified against this benefit in the policy schedule.

The e-counseling sessions shall be availed only through virtual modes of chat or tele etc. via our mobile application.

7. Diet and Nutrition e-Consultation

We will cover expenses incurred by the Insured Person on diet and nutrition e-consultation during the Policy Period on a virtual platform via our mobile application for the duration as specified against this benefit in the policy schedule.

The e-consultation shall be availed only through virtual modes of chat or tele etc. via our mobile application.

8. Preventive Care

Insured Persons aged 21 and above can avail a routine and preventive health check-up as per our pre- defined package (as mentioned in *Annexure A* to the policy wordings) at our network providers or health service providers anytime during the Policy period

This benefit can be availed only on cashless basis and is limited to once a year per Insured Person. The Health records in respect of the Insured Person shall be saved with Us in order to award wellbeing points as a part of the Wellbeing Program. They may be made available to Insured Person(s) in their medical vault in our mobile application.

9. Wellbeing Program

Wellbeing program intends to promote, incentivize and reward the Insured Person(s) for their healthy behavior through various wellbeing services. All the wellbeing activities as mentioned below in Table A enable the Insured Person(s) to earn wellbeing points which shall be monitored by the Health Coach.

The Health Coach shall only be available to Insured persons aged 21 and above. The Health Coach is a personalized service that shall encourage and promote optimal health and physical and mental wellbeing through a telephonic / digital connect The Insured Person shall have access to the health coach on downloading and registering on our mobile application. This activity needs to be done within 30 days of policy start date to ensure adequate utilization of services offered and to redeem the wellbeing points awarded.

Registered insured person(s) on successful completion of Health Risk Assessment [HRA] shall be evaluated by the Health Coach to assess and educate the Insured Person on adapting a healthy lifestyle

Table A- Journey of earning Wellbeing points

Category	Activity Details	Maximum Wellbeing Points Earned per Insured Person*
On boarding (mandatory to unlock earnings from other points based slabs)	Addition of BeFit Rider Details	500
	E-card Verification	300
Health Assessment	Health Risk Assessment	400
	Advisory on Preventive Care health check-up	300
	Medical Vault	300
	First usage of Chat with Health expert/ Health Coach Service	100

	Tele- consultations	300
Wellbeing activities	ICICI Lombard initiated Contest/ health quiz (Any one contest)	200
	ICICI Lombard initiated Webinar (Any one webinar)	200
Wellbeing Tasks	Achieving targeted steps per month	Maximum of 2400 per year
Fitness challenge	Participation and successful completion of fitness challenge	250 per challenge, maximum of 500 points
Health Events	Participation and successful completion of Health events	250 per event, maximum of 500 points
Grand Total		6000

* The Wellbeing Points to be awarded for each activity have been mentioned considering an individual BeFit rider for a single adult aged 21 and above. In case of a floater BeFit rider with 2 adults aged 21 and above, the wellbeing points to be awarded shall be doubled, provided, that both the Insured Persons complete their respective wellbeing activities.

Detailed explanation of Table A has been mentioned below

A. Onboarding

1. Addition of BeFit Rider Details

The insured person shall be awarded 500 welcome wellbeing points on downloading the mobile application recommended by Us and registering the policy details.

2. E-card Verification

The insured person shall be awarded 300 wellbeing points to view the E-card, verify the details mentioned on the same and confirm to Us about the same.

The wellbeing points awarded for onboarding i.e. for addition of BeFit Rider details and E-card verification shall only be onetime for the first year of the BeFit Rider and not for any subsequent renewals thereof.

B. Health Assessment

1. Health Risk Assessment [HRA]

The Health Risk Assessment (HRA) questionnaire is a tool for evaluation of the Insured Person's health and quality of life by reviewing the personal lifestyle practices affecting the Insured Person's health status. On taking the HRA test on our mobile application, within 90 days of policy start date, the Insured Person can earn a maximum of 400 wellbeing points under this activity.

2. Advisory on routine and preventive health check-up

The reports of the Preventive Care health check-up of the Insured Person if referred to our tele-consultation platform (example: IL Hello Doctor) for medical advisory and opinion, shall reward the Insured Person with a maximum of 300 wellbeing points

3. Medical Vault

The Insured Person has to save relevant medical records- diagnostic reports, prescriptions, routine and preventive health check-up reports in the medical vault on the mobile application. This activity shall reward the Insured Person a maximum of 300 wellbeing points.

4. First usage of Chat with Health Expert/ Health Coach Service

The Insured Person shall be rewarded 100 wellbeing points on the first time usage of the chat functionality on our mobile application. The Insured Person can virtually chat with health experts like physiotherapists, counsellors, dieticians etc. under this service

5. Tele-consultations

The Insured Person shall be rewarded 150 wellbeing points for an audio consultation with a Medical Practitioner through the mobile application. Maximum of 300 wellbeing points can be accrued under tele-consultations.

C. Wellbeing Activities

1. ICICI Lombard Initiated contest or health quiz

The Insured Person can earn wellbeing points by participating in any health related contests or quiz conducted by ICICI Lombard. Maximum of 200 wellbeing points can be earned through participating in such activities.

2. ICICI Lombard initiated Webinar

The insured person can earn a maximum of 200 wellbeing points on successful completion of any one health related webinar session conducted by ICICI Lombard.

D. Wellbeing Tasks

The insured Person shall be awarded wellbeing points as per the Table B mentioned below for achieving the targeted steps. The mobile application has to be downloaded within 30 days of the policy start date to avail this benefit as the average step count completed by an Insured person would be monitored on this mobile application.

Table B

Average Steps achieved per day for 20 days in a month	Maximum Wellbeing Points per month	Maximum Wellbeing Points accumulated in a year
8,000+ steps	200	2400
6,000 to 7,999 steps	150	1800
4,000 to 5,999 steps	120	1440
< 4,000 steps	Nil	Nil

E. Fitness Challenge

The Insured Person shall be awarded wellbeing points on participation and successful completion of a fitness challenge as initiated by Us from time to time. The insured person shall be awarded 200 wellbeing points per fitness challenge and the maximum wellbeing points that can be gained by participation and completion of the fitness challenges is 400.

F. Health Events

The insured person shall be awarded wellbeing points on participation and successful completion of health events as initiated by Us from time to time. The insured person shall be awarded 200 wellbeing points per health event and the maximum wellbeing points that can be gained by participation and completion of such health events is 400.

G. BeFit Benefit

The BeFit Benefit has been designed to reward the Insured Person(s) for their healthy behavior displayed throughout the year, which in turn resulted into partial utilization of the Routine Diagnostic and Minor Procedure cover and Pharmacy cover. The benefits are as per the table C mentioned below

Table C- BeFit Benefit

Utilization under routine diagnostic and minor procedure cover and Pharmacy cover	Wellbeing Points awarded
Up to 10% of Annual sum insured	100% of basic premium*
11% to 25% of Annual sum insured	60% of basic premium
26% to 40% of Annual sum insured	40% of basic premium
>40% of Annual sum insured	Nil

***** Basic premium refers to the premium charged to the Insured Person (i.e. premium excluding GST) as mentioned on the policy schedule

For example, the basic premium for an insured person is INR 5,000. The annual sum insured for routine diagnostic and minor procedure cover is INR 1,000 and the annual sum insured for pharmacy cover is INR 2,000. So the total SI for both the covers is INR

3000. In case the insured person(s) utilizes only INR 300 overall i.e. 10% of total SI, they shall be awarded 5000 wellbeing points as a part of the BeFit Benefit.

Also, As a Reward for the Insured Person's loyalty and long association with us, We shall increase the Rupee value of the Wellbeing Points Year on Year as per the Table D mentioned below:

Table D – Increase in Rupee Value of Wellbeing Points

Renewal year	Rupee Value of Wellbeing Points	Wellbeing Points	Rupee Value of Wellbeing Points
First Renewal (2nd Year of BeFit Rider)	INR 0.10	1000	INR 100
Second Renewal (3rd Year of BeFit Rider)	INR 0.12	1000	INR 120
Third Renewal (4th Year of BeFit Rider)	INR 0.15	1000	INR 150
Fourth Renewal (5th Year of BeFit Rider)	INR 0.20	1000	INR 200

H. Redemption of Wellbeing Points

The Wellbeing points earned by the Insured Person (as detailed in Table A and Table C) can be redeemed in any of the below mentioned ways

1. Discount on Renewal premium- The Wellbeing points earned by the Insured Person can be redeemed to avail a discount on renewal premium. However, the maximum discount that the Insured Person can avail shall be as per the Table E below:

Table E – Maximum discount that can be availed by Insured Person

Year of BeFit Rider	**Maximum Discount that can be availed as % of basic premium***
1st Year	20
2nd Year	20
3rd Year	25
4th Year	25
5th Year	25

***** Basic premium refers to the premium charged to the Insured Person (i.e. premium excluding GST) as mentioned on the policy schedule.

2. Wellbeing points accumulated by the Insured Person (as detailed in Table A + Table C) can be redeemed against health related deals and offers on health supplements, dietary supplements, food supplements etc., only as available on our platform of mobile application or through our specified network providers or health service providers.

Illustration for redemption of Wellbeing Points

Below mentioned Table F is a road map journey of 5 years for an individual BeFit Rider

Table F

	Particulars	Fresh Policy	1st Renewal	2nd Renewal	3rd Renewal	4th Renewal
		1st Year	2nd Year	3rd year	4th Year	5th Year
A	Basic Premium w/o GST (INR)	5,000	5,000	5,000	5,000	5,000
B	Renewal Discount (INR)	-	1,000	1,000	1,250	1,250
C	Renewal Premium (A-B) (INR)	-	4,000	4,000	3,750	3,750
D	**Maximum Wellbeing Points that can be accrued (through wellbeing program)**	**6,000**	**6,000**	**6,000**	**6,000**	**6,000**
E	**Maximum Wellbeing Points accrued (through BeFit Benefit)**	**5,000**	**5,000**	**5,000**	**5,000**	**5,000**
F	**Total Points accumulated (D+E)**	**11,000**	**11,000**	**11,000**	**11,000**	**11,000**
G	Value of 1 wellbeing point (INR)	0.10	0.12	0.15	0.20	0.20
H	Value in terms of INR (F*G) (INR)	1,100	1,320	1,650	2,200	2,200
I	Maximum discount that can be availed	20% of the base premium		25% of the base premium		
J	Maximum rupee discount can be availed as renewal premium discount (I*A) (INR)	1,000	1,000	1,250	1,250	1,250
K	Balance can be availed against health related deals & offers on mobile application (H-J) (INR)	100	320	400	950	950

Terms and Conditions for Redemption of Wellbeing Points

- The Insured Person has to accumulate minimum 1000 wellbeing points in order to redeem them against discount on renewal premium. There shall be no minimum points limit for redemption against health related deals and offers on mobile application.
- Alternately, the Insured Person(s) can even choose to carry forward the wellbeing points for 3 years, in case they do not wish to redeem the same provided the policy is continuously renewed without any break.

Terms and conditions for availing the Wellbeing Program:

- For health risk assessment [HRA] services availed through mobile application/online/ digital mode on IL Platform, the Insured Person shall be required to provide the details in order to establish authenticity and validity prior to availing such services. Any such information provided by the Insured Person in this regard shall be used solely for the purpose of providing these wellbeing services and kept confidential with Us/Our Network Providers/Health Service Providers at all times.
- The Insured Person shall notify Us and submit the relevant documents, reports, receipts as and when required by us within 60 days of undertaking any wellbeing activity.
- The Insured Person agrees that choosing to utilize any of the wellbeing services or any information or advise rendered by Our Health Service Providers or Network Providers or Us will be solely at the Insured Person's discretion and own risk and should not be, used to diagnose or identify treatment for a medical or mental health condition.
- The Wellbeing Points earned by the Insured person through the Wellbeing Program can be carried forward for a maximum of 3 years and shall have to be redeemed at the end of the 3rd Policy Year.
- In case, the Insured Person does not wish to redeem the wellbeing points earned, the same will be forfeited.
- In case of expiry of policy, the accrued wellbeing points may be carried forward for a period not exceeding three months
- There shall not be any cash reimbursement or redemption available against the wellbeing points accumulated by an Insured Person.
- We or Our Health Service Providers or Our Network Providers do not warrant the validity, accuracy, completeness, safety, quality, or applicability of the content or anything said or written or any suggestions provided in the course of providing the wellbeing services.
- We, Our group entities, or affiliates, their respective directors, officers, employees, agents, vendors, shall not be responsible for or liable for, any actions, claims, demands, losses, damages, costs, charges and expenses which an Insured Person may claim to have suffered, sustained or incurred, as a result of any advice or information obtained by way of the wellbeing program or any actions chosen by the Insured Person on the basis of such advice or information.
- The wellbeing program offered is subject to revisions based on the insurance regulatory framework from time to time.

Disclaimers

- *Choosing the option is purely on Insured Person's discretion and at own risk.*
- *The wellbeing program is intended to provide support information to the Insured Person to improve well-being and habits through working towards obtaining a healthy lifestyle, and does not constitute medical advice and/or substitute the Insured Person's visit/ consultation to an independent Medical Practitioner.*
- *We reserve the right to remove or reduce wellbeing points in case the same have been found to be achieved in any unfair manner by manipulation*
- *Availing the service provided by our Health Service Providers / Network Provider is at the sole discretion of the Insured person and We are not liable, responsible or deemed to be liable or responsible for any discrepancy in the information or Medical Advice provided.*

10. Health Management Program (HMP)

The HMP has been designed to ensure a regular monitoring of the Insured Person's health and timely intervention and a concrete plan for corrective measures in case of any decline in the health status of the Insured Person.

The insured person shall be subjected to a mid- term assessment via a Wellbeing Risk Assessment [WRA] which includes the Preventive Care health check-up-outcomes and questionnaire based assessment covering aspects of lifestyle, current medical history & family history. The assessment will be carried out using a telephonic/ digital connect with the Health Coach. In case of any adverse health conditions/life style diseases the Insured Person shall be mandatorily shifted to HMP at the time of renewal of the policy. This mid-term assessment will be carried out every year to monitor the health condition of the insured person.

The lifestyle/health conditions of the insured person that shall be considered for HMP will include the below mentioned 37 health conditions.

1. Hypertension *(refer levels defined in Table G & H)*
2. Diabetes Mellitus *(refer levels defined in Table G & H)*
3. Obesity *(refer levels defined in Table G & H)*
4. Hyperlipidemia *(refer levels defined in Table G & H)*
5. Myocardial Infarction
6. Refractory heart failure
7. Cardiomyopathy
8. End stage lung Failure
9. Primary(Idiopathic) pulmonary Hypertension
10. End stage liver Failure
11. Multiple sclerosis with Persisting symptoms
12. Motor neuron disease with Permanent symptoms
13. Permanent paralysis of limbs
14. Stroke resulting in permanent symptoms
15. Coma of specified severity
16. Alzheimer's Disease before age of 50 years
17. Parkinson's disease before age of 50 years
18. Apallic syndrome
19. Benign brain tumour
20. Creutzfeldt-Jakob disease (CJD)
21. Major head trauma
22. Kidney failure requiring regular dialysis
23. Medullary cystic disease
24. Muscular dystrophy
25. Poliomyelitis
26. Aplastic Anaemia
27. Systemic Lupus Erythematous with renal involvement

28. Myasthenia gravis
29. Scleroderma
30. Good pastures syndrome with lung or renal involvement
31. Blindness
32. Deafness
33. Cancer of specified severity
34. Third Degree Burns
35. Loss of speech
36. Loss of limbs
37. Loss of Independent Existence

Once the insured person(s) qualifies for the Health management Program, they shall have to pay the HMP premium and follow the customized Health Management program which has been designed for that category to achieve their respective health goals. The insured person will have to be part of the eligible plan and Health Management program for a consecutive period of 2 years. Post the successful completion of 2 years in the health management program, the health condition of the insured person will be reviewed by the health coach. Basis the health condition at the time of review, it will be decided whether the insured person needs to continue with the Health Management program or not.

The health check-up outcome that will be used for categorization purpose of Hypertension, Diabetes Mellitus, Obesity, Hyperlipidemia is mentioned below in Table G and Table H

.

Table G (applicable for first time buyer)

Medical Tests	Category 1 (Normal Program)	Category 2 (Health Management Program)
Glycosylated Hemoglobin (HbA1c)	< 6%	>6 and up to7%
Blood Pressure reading	Systolic Up to 120 mm hg Diastolic Up to 80 mm hg	Systolic >120mm and <140 mmhg Diastolic > 80 mm and <90 mm hg
Low Density Lipoprotein (LDL)	< 100 mg/dl	>100 and < or = 190 mg/dl
High Density Lipoprotein (HDL)	> or = 40 mg/dl	> 20 mg/dl and <40 mg/dl
Serum cholesterol	< or = 200mg/dl	>200 and < or =300 mg/dl
Triglycerides	<or = 150 mg/dl	> 150 and <= 250mg/dl
Body Mass Index (BMI)	< or = 32	>32 and < or = 40

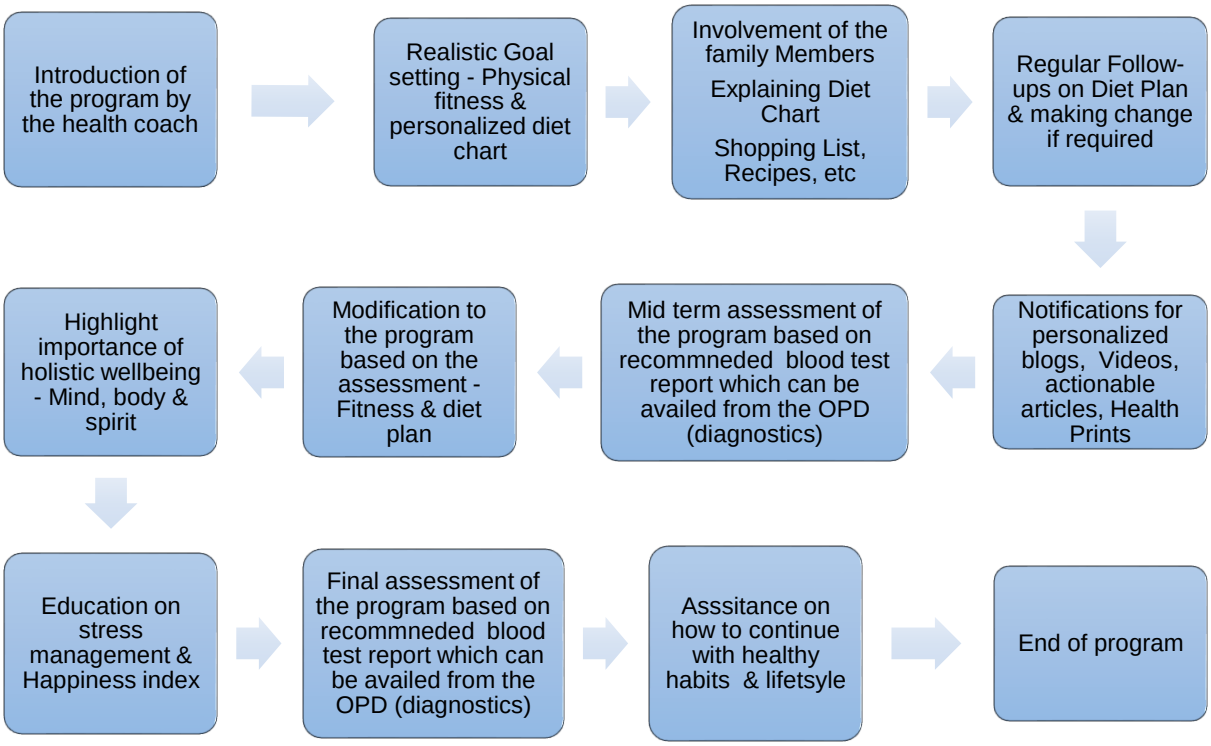
Table H (for renewal customers)

Medical Tests	Category 1 (Normal Program)	Category 2 (Health Management Program)
Glycosylated Hemoglobin (HbA1c)	< 6%	>6%
Blood Pressure reading	Systolic Up to 120 mm hg Diastolic Up to 80 mm hg	Systolic >120mm Diastolic > 80 mm
Low Density Lipoprotein (LDL)	< 100 mg/dl	>100 mg/dl
High Density Lipoprotein (HDL)	> or = 40 mg/dl	> 20 mg/dl
Serum cholesterol	< or = 200mg/dl	>200 mg/dl
Triglycerides	<or = 150 mg/dl	> 150 mg/dl
Body Mass Index (BMI)	< or = 32	>32

The HMP can also be voluntarily opted by Insured person(s) even if they are found to be fit, basis the wellbeing risk assessment, as a conscious step towards healthier living by paying the requisite premium for it and avail the benefits of the HMP.

How does the HMP work?

It offers personalized healthcare & lifestyle care management by a Health Coach using digital platform for chronic & lifestyle related diseases. The health parameters of the Insured Person will be monitored under the guidance of a professional health coach



Additional components of HMP: -

- Reminders on medicines and diagnostic test
- The insured person will also be eligible for an additional 3 Tele-consultations & 3 e-counselling sessions

11. Ambulance Assistance

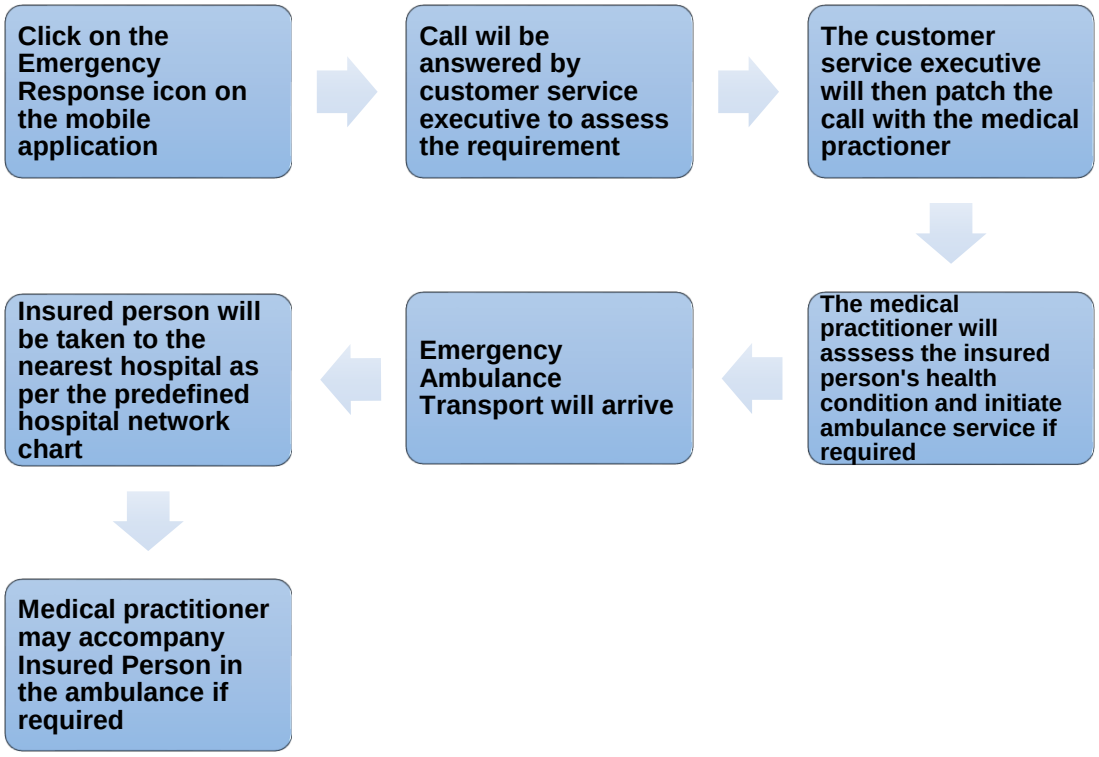
We shall arrange ground medical transportation by a Health Service provider to transport the Insured Person to the nearest Hospital or any clinic or nursing home for medically necessary treatment subject to availability of services in that particular city/location. Kindly visit our mobile application for updated list of cities/locations where the services are provided.

1. The services under this Benefit are subject to the following conditions:
   - The medical transportation is for a life threatening health condition of the Insured Person which requires immediate and rapid transportation to the Hospital; as certified in writing by the Medical practitioner

- The Insured Person is in India and the treatment is in India only;
- The ambulance service is availed within the same city

How to Call an Ambulance?

`



Disclaimer: This is only an assistance service to arrange for an ambulance, the cost of the ambulance has to be borne by the Insured Person himself/herself, as per the invoice provided at the time of availing the service. There is no restriction on the number of times the Ambulance Assistance can be availed.

12. Value Added Services

We at the request of the Insured Person shall arrange or shall facilitate the following additional services through Our empanelled health service provider

- Deals & Discounts on services/products provided by our network providers/ Health service providers – We shall only facilitate the Insured Person in availing deals and discounts on services/products offered by our network providers/ health service providers. In case of exhaustion of annual sum insured under the BeFit rider benefits mentioned above, the Insured Person

can still avail the discount provided by our network providers/health service providers, in which case the actual cost of the product/service shall have to be borne by the Insured Person.

- Health Assistance (HAT)

Health Assistance (HAT)

We also provide Health Assistance as a part of Our Value added services, Our Health Assistance Team (HAT) shall assist the Insured Person in understanding the health condition better by providing answers to any queries related to health service provider through our mobile application.

The services provided under this shall include:

- Identifying a Physician/ Specialist
- Scheduling an appointment with any Medical Practitioner empanelled with Us
- Scheduling appointments for a second opinion
- Providing suitable options with respect to Hospitals as well as providing assistance in Cashless facility, wherever applicable.
- Providing preventive information on ailments
- Providing guidance on post Hospitalization care, such as Physiotherapy/ Nursing at home.

Please note that services provided under this Benefit are solely for assistance, and should not be construed to be a substitute for a visit/ consultation to an independent Medical Practitioner. This Benefit does not include the charges for any independent Medical Practitioner/nutritionist consulted on HAT's recommendation, and such charges are to be borne by the Insured Person.

Disclaimer:

- Choosing the option is purely on insured person's discretion and at own risk. We are only acting as facilitators and are not liable for any costs of the services.
- We do not accept any liability towards quality of the services made available by our network providers/ health service providers and are not liable for any defects or deficiencies on their part
- Service facilitation is subject to availability of Health Service provider at the requested location
- In case of Emergency, please visit the nearest hospital without waiting for assistance service
- In case of cancellation/delay of appointment due to unavoidable circumstances insured person can proceed to the nearest hospital as per own choice.
- Cost of service rendered by the Health Service provider should be borne by the insured person unless cashless service confirmation is provided by ICICI Lombard

How to avail Health Assistance services?

This service is available from 8am to 8pm from Monday to Saturday except public holidays

By availing this service, the Insured person agrees and has no objection to the health records being maintained with Us for internal use only.

While deciding to obtain such value added service, the Insured person(s) expressly notes and agrees that it is entirely for them to decide whether to obtain these services and also to decide the use (if any) to which these services are to be put for.

e) Exclusions

All exclusions as mentioned in the Base Product will be applicable to the BeFit rider unless otherwise stated and covered in Section II of BeFit Rider policy wordings.

i. Standard Exclusions (Exclusions for which standard wordings are specified by IRDAI)

Code- Excl05: Exclusion Name: Rest Cure, rehabilitation and respite care

a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
   I. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
   II. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

ii. Specific Exclusions (Exclusions other than those mentioned under e(i) above)

1. **Waiting Period:** There shall be a waiting period of 30 days applicable for all benefits under this BeFit rider.

2. **General Condition:** We shall not make any payment for any claim in respect of any Insured Person directly or indirectly for, caused by, arising from or in any way attributable to any of the following unless expressly stated to the contrary in this BeFit rider.
   a. Medical Exclusion:
      i. Inpatient treatment and day care treatments shall not be covered under this product
   b. Non- Medical Exclusions:

i. Any item(s) or treatment specified in list of excluded expenses (non-medical) and available on Our web site, unless specifically covered under the BeFit rider.

f) General Terms & Clauses

All general terms and conditions as mentioned in the Base Product will be applicable to the BeFit rider unless otherwise stated.

Policy duration of the BeFit Rider shall be a minimum period of 1 year and a maximum period of 3 years subject to the tenure of the Base Product.

i. Standard General Terms and Conditions (General terms and clauses whose wordings are specified by IRDAI

1. Redressal of Grievances

In case of any grievance the insured person (including senior citizens) may contact the company through

Website: www.icicilombard.com

Toll free: 1800 2666

Email: customersupport@icicilombard.com

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance. If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at

Manager- Service Quality,

Corporate Manager- Service Quality,

National Manager- Operations & finally

Director-services and Business development at the following address:

ICICI Lombard General Insurance Company Limited,

ICICI Lombard House,

414, P Balu Marg, Off Veer Savarkar Road,

Nr Siddhi Vinayak Temple,

Prabhadevi, Mumbai 400025For updated details of grievance officer, kindly refer the link https://www.icicilombard.com/grievance-redressal

If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017. The contact details of the ombudsman have been provided as an annexure to the policy wordings of the base product

Grievance may also be lodged at IRDAI Integrated Grievance Management System - https:/igms. irda.qov. in/

ii. Specific Terms and Clauses (terms and clauses other than those mentioned under f(i))

1. Notices

Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post, or facsimile to:

In Your case, at Your last known address.

In Our case:

ICICI Lombard General Insurance Company Limited

ICICI Lombard House

414, P Balu Marg, Off Veer Savarkar Road,

Nr Siddhi Vinayak Temple,

Prabhadevi, Mumbai 400025

Notice and instructions will be deemed served 7 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

2. Cancellation

i. The Policyholder may cancel this Policy at any time by giving Us written notice. The cancellation shall be from the date of receipt of such written notice. Premium shall be refunded as per the base health product if and only if no claim has been made under this BeFit Rider.

ii. The Company may cancel the Policy at any time on grounds of mis-representation, non-disclosure of material facts, fraud by the Insured Person, by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of mis-representation, non-disclosure of material facts or fraud.

3. Customer Service

If at any time You require any clarification or assistance, You may contact Our offices at the address specified, during normal business hours.

g) Other Terms and Conditions

CLAIM PROCEDURE

All claims will be adjudicated only on cashless basis via our mobile application and are subject to the terms, conditions, waiting periods and exclusions of the BeFit rider and the availability of the Annual sum insured.

Cashless facility is only available at specific Network Providers/Health Service Provider available on the mobile application. We reserve the right to modify, add or restrict any Network Provider/Health Service Provider for Cashless facility at Our sole discretion.

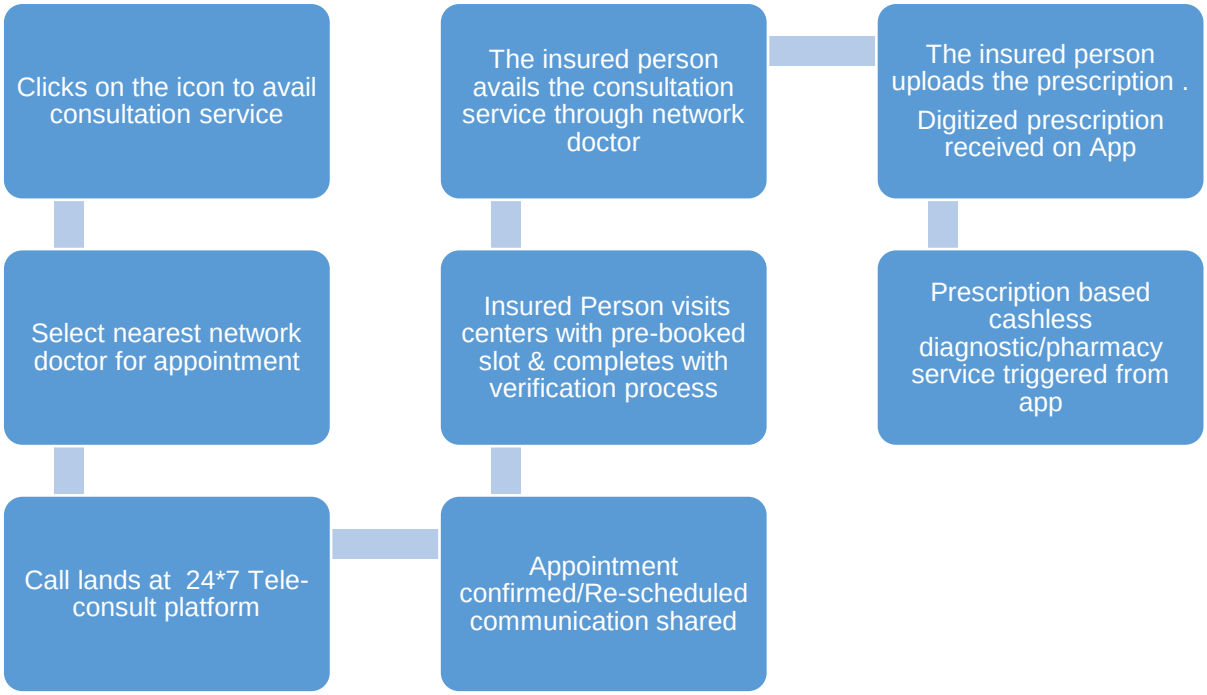
- To avail of Cashless facility at the health service provider / Network Provider, the Insured Person/claimant is required to produce information on the health card available on the application for verification and validation. The request shall be considered after having obtained accurate and complete information for the Illness or Injury, where applicable, for which Cashless facility is sought and We shall confirm the request digitally.
- In case the services availed exceed the eligibility of the BeFit Rider, the difference shall have to be paid directly to the Hospital/Network Provider/Health Service Provider by the Insured person/claimant.
- To avail the benefits and services under the BeFit Rider, Insured Person shall need to raise a request through mobile application
- The Routine diagnostic and minor procedure cover /Pharmacy cover services shall only be covered for prescriptions by an empaneled Network Medical Practitioner through the Mobile Application.

How to avail the cashless services under the BeFit rider on the mobile application

1. The Insured Person will have to download the mobile application from the app store/playstore. Post download the insured person will have to complete the registration process and login to the home page.

2. On the home page, the Insured person will have to go to visit the out-patient service section like consultation, diagnostics and pharmacy

   A schematic representation of the claims process is as below


Clicks on the icon to avail consultation service
Select nearest network doctor for appointment
Call lands at 24*7 Tele-consult platform
Appointment confirmed/Re-scheduled communication shared
Insured Person visits centers with pre-booked slot & completes with verification process
The insured person avails the consultation service through network doctor
Prescription based cashless diagnostic/pharmacy service triggered from app
The insured person uploads the prescription .
Digitized prescription received on App

Annexure A – List of Routine and Preventive Health check- up tests that are a part of the Section II. 8. Preventive care

This list is subject to amendment from time to time.

Package	Plan C	Plan D	Plan E	Plan F
Parameters				
Vitals				
BP	Y	Y	Y	Y
Pulse rate	Y	Y	Y	Y
WHR	Y	Y	Y	Y
BMI	Y	Y	Y	Y
SPO2	Y	Y	Y	Y
Weight	Y	Y	Y	Y
Blood Parameters				
ESR		Y	Y	Y
TSH	-	-	Y	Y
T3	-	-	Y	Y
T4	-	-	Y	Y
T Cholestrol				-
LDL	Y	Y	Y	Y
VLDL	Y	Y	Y	Y
HDL	Y	Y	Y	Y
Triglyceride	Y	Y	Y	Y
HBA1C	Y	Y	Y	Y
Urine Sugar		Y	Y	Y
Creatinine	Y	Y	-	-
BUN	Y	Y	Y	Y
Uric acid		Y	Y	Y
Vitamin B12				Y

Ishield_ICICI_Pru_iProtect_Smart_Annexure_V Policy_Document_Option_Life

A Non-Linked Non-Par Life Individual pure risk premium product

Dear <Customer Name>,
This is your life insurance policy. It is a legal
Document. Please read it carefully.
We have highlighted some important points regarding your policy that you should keep in mind:

1. **YOUR POLICY DETAILS**
Name of your plan :<<Product Name>>
Policy Number : <Policy Number>
Mobile Number :<Mobile Number>
Email ID : <Email ID>
Person insured in this policy: <Name of Life Assured>
Sum Assured (Insurance Cover Amount) (in ‘) : <Amount>
Premium Instalment (in ‘) : <Amount>
Payment frequency :<Payment Frequency>
Next premium due date : <Date>
You need to pay premiums for: PPT in years
Policy Term : <Policy Term> years
Policy end date: <Date of Maturity>

In case of any discrepancies in the above details please inform us immediately.

About the Advisor

Name : <Advisor Name>
Code / License Number : <Advisor Code>
Contact Number : <Advisor Contact>
Address : <Advisor address>

You may contact your advisor for any queries you have or any clarifications that you require in relation to the Policy Terms and conditions or any policy servicing requirements.

2. **YOUR FREE LOOK PERIOD**
You have an option to review the policy within <15/30> days from the date you receive it. In this period, if you are not satisfied with the policy terms and conditions, you can return the policy to us with reasons for cancellation. We will refund the premium paid after deduction of Stamp duty, proportionate risk premium and expenses for medical tests if any.

3. MAKING A CLAIM
You can contact Us on 1-860-266-7766 for any claims to be made under the policy and we will assist the claimant through the entire process.
In case of any queries or clarifications required, please feel free to contact your advisor or reach us at any of our service centres mentioned below. We will be happy to assist you. Warm regards,

<<< Authorised Signatory >>>

Visit us at

<<< Designation >>> www.iciciprulife.com

Write to us at: Email us at: Customer Service Helpline
ICICI Prudential Life Insurance Co. Ltd. lifeline@iciciprulife.com 1860 266 7766
Ground Floor & Upper Basement,
Unit No. 1A & 2A, Raheja Tipco Plaza,
Rani Sati Marg, Malad (East),Mumbai- 400097
Maharashtra.

ICICI Prudential Life Insurance Co. Ltd. Registered Address: ICICI Pru Life Towers,
1089, Appasaheb Marathe Marg, Prabhadevi, Mumbai-400025.
Reg No:105. Insurance is the subject matter of the solicitation.
Unique Identification Number as specified by IRDAI 105N151V08

Policy Schedule ICICI Pru iProtect Smart (UIN: 105N151V08)
(This is a Non-Linked Non-Par Life Individual pure risk premium product)

Policy Preamble

This Policy is the evidence of a contract between ICICI Prudential Life Insurance Company Limited (Us/We/Company) and the Policyholder (You) referred to below.

We have issued this Policy on the basis of the details provided by You in the Proposal Form submitted along with the required declarations, personal statement, applicable medical reports, the first premium deposit and any other information and documentation which constitute evidence of the insurability of the Life Assured for the issuance of the Policy.

We agree to provide the benefits set out in this Policy subject to its terms and conditions.

Policy Schedule

Name of the Life Assured:

Address:	Category: Medical/Non-Medical		
Date of Birth:	Age (Years):	Gender: M/F/T	Age Admitted: Y/N

Name of the Policyholder:

Policy No:	Benefit Option:

Policy Issue Date:	Date of Maturity:
Policy Acceptance Date:	Policy Term in years:

Premium Payment Term in years:	Periodicity of payment of premium (premium frequency):
Premium payment option:	Accelerated Critical Illness Benefit Term in years:
Total instalment premium (Rs.):	Accelerated Critical Illness Benefit (Rs.):
Sum Assured (Rs.):	Policy sourced by Distance Mode: Y/N
Accidental Death Benefit (Rs.):	Accidental Death Benefit Term in years:
Death Benefit Payout Option: Option / Sum Assured payable Lump sum Income Increasing Income	Due date of last premium payable:

Nominee(s) Name	Gender	Nominee's Age	Percentage Share	Relationship to the Life Assured	Appointee Name [in case the Nominee is a minor]	Appointee's Gender	Appointee's Age	Relationship of the appointee with the Life Assured

Goods and Services Tax and/or cesses would be charged extra, as applicable.

Policy Schedule, terms and conditions of the Policy and the endorsements by Us, if any, shall form an integral part of this contract and shall be binding on Us and You.

The Policy shall stand cancelled by Us, without any further notice, in the event of dishonour of the first premium deposit.

Please immediately inform Us about any change in address or contact details.

Signed for and on behalf of the ICICI Prudential Life Insurance Company Limited, at Head Office, Mumbai on ……. (Issue Date)
<<<Authorised Signatory >>>
<<<Designation>>>

Version ……

Stamp duty of Rs. …….. (Rupees …….Only) paid by Pay order, vide receipt no. …… dated ……...
This is an output of a digitally signed print file

Please examine the policy and approach Us immediately in case of any discrepancies.

PART B

Definitions

1. Age means age at last birthday.
2. Accident means a sudden, unforeseen and involuntary event caused by external, visible and violent means.
3. Annualized Premium means the premium amount payable in a year chosen by the policyholder, excluding the taxes, rider premiums, underwriting extra premiums and loadings for modal premiums, if any.
4. Appointee means the person appointed by You to receive the benefits payable under the Policy till Your Nominee is a minor.
5. Death Benefit means the benefit, which is payable on death or diagnosis of Terminal Illness as specified in the Policy document.
6. Death Benefit Payout Option is the manner in which the nominee receives the Death Benefit payable under the Policy.

7. Claimant means the person entitled to receive the Policy benefits and includes the You, the nominee, the assignee, the legal heir, the legal representative(s) or the holder(s) of succession certificate as the case may be.
8. Date of commencement of risk is later of Policy Issue Date or Policy Acceptance Date
9. Date of Maturity means the date specified in the Policy Schedule on which the term of the Policy ends.
10. Distance Mode means every activity of solicitation (including lead generation) and sale of insurance products through the following modes: (i) voice mode, which includes telephone-calling (ii) short messaging service (SMS) (iii) electronic mode which includes e-mail, internet and interactive television (DTH) (iv) physical mode which includes direct postal mail and newspaper and magazine inserts and (v) solicitation through any means of communication other than in person.
11. Insured event is the event on the happening of which, benefits under Your policy become payable.
12. Life Assured means the person named in the Policy Schedule on whose life the Policy has been issued.
13. Limited Pay means premiums need to be paid regularly for a limited portion of the Policy Term.
14. Medical Practitioner is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of licence The Medical Practitioner should neither be the insured person(s) himself nor related to the insured person(s) by blood or marriage.
15. Nominee means the person named in the Policy Schedule who has been nominated by You to receive benefits in respect of this Policy.
16. Policy means the contract of Insurance entered into between You and Us as evidenced by the "Policy document".
17. Policy Acceptance Date means the date as specified in the Policy Schedule, from which the policy was effected.
18. Policy document means this document, the Proposal Form, the Policy Schedule and any additional information/document(s) provided to Us in respect of the Proposal Form, and any endorsement issued by Us.
19. Policy Issue Date means the date as specified in the Policy Schedule.
20. Policyholder or the Proposer or You or Your means the owner of the Policy at any point of time.
21. Policy Term means the period between the Policy Acceptance Date and the Date of Maturity specified in the Policy Schedule.
22. Policy Schedule means the policy schedule and any endorsements attached to and forming part of this Policy.
23. Premium means the instalment premium in case of Regular Pay and Limited Pay or single premium in case of Single Pay specified in the Policy Schedule which is payable/has been received under the Policy.
24. Premium Payment Term means the period specified in the Policy Schedule during which Premium is payable.
25. Proposal Form means a form to be completed by You for availing an insurance policy, and to furnish all Material information required by Us to assess risk and to decline or to undertake the risk, and in the event of acceptance of risk, to determine the rates, advantages, terms and conditions of a cover to be granted.
    Explanation: "Material" shall mean and include all important, essential and relevant information that enables Us to take an informed decision while underwriting the risk.
26. Regulator means the authority that has regulatory jurisdiction and powers over Us. Currently the Regulator is the Insurance Regulatory and Development Authority of India (IRDAI).
27. Regular Pay means premiums need to be paid regularly throughout the Policy term.
28. Revival of the Policy means restoration of Policy benefits.

29. Revival period means the period of five consecutive years from the due date of the first unpaid premium and before the termination date of the Policy, during which period You are entitled to revive the policy.
30. Single Pay means premium needs to be paid once at the start of the Policy.
31. Sum Assured means the amount specified in the Policy Schedule.
32. Surrender means complete withdrawal/termination of the Policy by You.
33. Total Premiums Paid means the total of all premiums received, excluding any extra premium, any rider premium and taxes.
34. Unexpired risk premium value means an amount, if any, that becomes payable in case of surrender or discontinuance of premium in single/ limited pay policies in accordance with the terms and conditions of the Policy.
35. You or Your means the Policyholder of the Policy at any point of time.
36. We or Us or Our or Company means ICICI Prudential Life Insurance Company Limited.

PART C

1. Benefits available under the policy:

1.1 Death Benefit

We shall pay the Death Benefit as per the Death Benefit Payout Option stated on Your Policy Schedule upon diagnosis of Terminal Illness or death of the Life Assured whichever is earlier provided the Policy is in force as on the date of diagnosis of Terminal Illness or the date of death of the Life Assured. A Life Assured shall be regarded as "Terminally Ill" only if that Life Assured is diagnosed as suffering from a condition which, in the opinion of two independent Medical Practitioners, specializing in treatment of such illness, is highly likely to lead to death within 6 months. The terminal illness must be diagnosed and confirmed by Medical Practitioners registered with Indian Medical Association and approved by Us. We reserve the right for independent assessment of the Terminal Illness. Death Benefit would be as per the below table:

Premium Payment Option	Death Benefit
Single Pay	Higher of 125% of the single premium or the sum assured as stated on your policy schedule to be paid on death.
Regular Pay and Limited Pay	Higher of 7 times the annualized premium or 105% of the total premiums received up to the date of death or the sum assured as stated on your policy schedule to be paid on death.

a. The Policy shall terminate on payment of the benefit and all rights, benefits and interests under the Policy shall stand extinguished.
b. The benefit amount may be taxable as per the prevailing tax laws.

1.2 Waiver of Premium on Permanent Disability due to accident

a. Upon the diagnosis of Permanent Disability (as defined below) of the Life Insured which arises due to an Accident, We shall waive all future premiums payable for all benefits under the Policy during the remaining Premium Payment Term of the Policy provided the Policy is in force as on the date of diagnosis of Permanent Disability of the Life Assured. The Policy will continue for the Death Benefit.

b. For the purpose of this benefit, " Permanent Disability" means the inability of the Life Assured to perform at least 3 of the following 6 activities of daily work:
   - Mobility: The ability to walk a distance of 200 meters on flat ground.
   - Bending: The ability to bend or kneel to touch the floor and straighten up again and the ability to get into a standard saloon car, and out again.
   - Climbing: The ability to climb up a flight of 12 stairs and down again, using the handrail if needed.
   - Lifting: The ability to pick up an object weighing 2kg at table height and hold for 60 seconds before replacing the object on the table.
   - Writing: The manual dexterity to write legibly using a pen or pencil, or type using a desktop personal computer keyboard.
   - Blindness: The permanent and irreversible loss of sight to the extent that even when tested with the use of visual aids, vision is measured at 3/60 or worse in the better eye using a Snellen eye chart.

c. Provided that the disability should have lasted for at least 180 days without interruption and must be deemed permanent by a Company empanelled Medical Practitioner. In the event of death of the insured within the above period, the policy shall terminate on payment of applicable benefits and all rights, benefits and interests under the policy shall stand extinguished.

This Benefit is not applicable for Single Pay policies.

1.3 Death Benefit Payout Options

The Death Benefit will be payable as per one of the below options chosen by You at the inception of Your policy and mentioned in Your Policy Schedule.

1. Lump Sum Option – Entire Death Benefit amount is payable as lump sum.
2. Income Option – 10% of the Death Benefit amount is payable every year for 10 years. This will be payable in equal monthly instalments in advance at the rate of 0.83333% of Death Benefit amount.
   The beneficiary can also advance the first year's income as a lump sum. The monthly income will then continue from the subsequent month for next 9 years advance at the rate of 0.80% of Death Benefit amount.
3. Lump sum and Income – The part of the Death Benefit amount to be paid out as lump sum is chosen at inception. The balance Death Benefit amount will be paid out in equal monthly instalments in advance at the rate of 0.8333% per month over 10 years.
4. Increasing Income Option – Benefit amount is payable in monthly instalments for 10 years starting with 10% of the benefit amount per annum in the first year. The income amount will increase at 10% p.a. simple interest every year thereafter.

For options 2, 3, and 4, You or the nominee as the case may be, will have an option to take the discounted value of the future payouts anytime during the payout term by informing Us of this decision in writing. The present value will be derived using discount rate of 4% p.a..

1.4 Smart Exit Benefit

You have an option to cancel the Policy and receive Smart Exit Benefit, equal to Total Premiums Paid under the Policy. No additional premium is payable to avail this option.

The following conditions are applicable for availing Smart Exit benefit:

- The Sum Assured in the policy at inception is ₹ 6,000,000 or above.
- This option can be exercised in any policy year greater than 25 but not during the last 5 policy years, provided the age of the life assured is 60 years or more at the time of exercise.
- The Policy is in-force with all due premiums paid at the time of exercising this option.
- No claim for any of the underlying benefits has been registered and is under evaluation/ or accepted/ or paid/ being paid on the Policy.

The Policy shall terminate on payment of this benefit (if exercised) and all rights, benefits and interests under this Policy will stand extinguished. You can either opt for Smart Exit Benefit or Unexpired Risk Premium Value as per Clause 3, Part D, i.e. you cannot avail both the benefits simultaneously.

Where Life Stage Protection options has been exercised, Total Premiums Paid includes Premium paid for each tranche of additional sum assured purchased.

1.5 Life Stage Protection

You can choose to increase the Death Benefit at the key milestones of marriage and child birth/ adoption of child, provided no claim has been admitted for any benefits under the policy and the policy is in force.

The Death Benefit can be increased without any medicals on any one or all of the below events during the term of the Policy. This feature is available to a Life Assured underwritten as a standard life at the time of inception of the Policy per the Board Approved Underwriting Policy.

Event	Additional Death Benefit (percentage of original Sum Assured)	Subject to maximum additional Death Benefit
Marriage	50%	Rs. 50,00,000
Birth / Legal adoption of 1st child	25%	Rs. 25,00,000
Birth / Legal adoption of 2nd child	25%	Rs. 25,00,000

On exercising the option, You will have to pay an additional premium for the additional Sum Assured for the outstanding term of the policy based on your then age. Hence the future premium payable by You on exercising this option will be the sum of original premium and additional premium.

No fee is chargeable for this option.

This feature is available only with Regular premium payment option. Such increase in sum assured is only applicable to base death benefit. The AD Benefit will remain unchanged.
Premium will be recalculated based on the increased Death Sum Assured and outstanding policy term. This is subject to:

1. Minimum policy term (which is 5 years) available at the time of the exercising this feature.
2. The Life Assured being less than 50 years of age at the time of the event.

Such increase needs to be exercised within 6 months of the event and will be effective from the next policy anniversary. The additional premium will also be payable from next policy anniversary.

1.6 You have an option to add Accidental Death(AD) Benefit anytime during the policy term except in last 5 years, for which the following conditions apply:

- It can be opted in Regular Pay Policies only
- The policy must be in-force at the time of adding the Benefit
- There must not have been any claim in the policy till the time of opting of AD Benefit
- The availability of the AD benefit will be subject to underwriting, as per the prevailing board approved underwriting policy
- The AD Benefit will commence from subsequent policy anniversary for the remaining policy term or till age 80, whichever is lower. You will have to pay an additional premium corresponding to this Benefit. Life Assured's then age must be less than or equal to 55 years(age last birthday)
- The Benefit once added, cannot be removed.

2. Premium payment:

i. You are required to pay Premiums on the due dates and for the amount mentioned in the Policy Schedule.

ii. The grace period for payment of premium is 15 days for monthly frequency of premium payment and 30 days for other frequencies of premium payment. In case of occurrence of the covered events during the grace period, We will pay the benefits as per the terms and conditions of the Policy.

iii. If any premium instalment is not paid within the grace period then the Policy shall lapse and all cover under the Policy will cease.

iv. You are required to pay Premiums for the entire Premium Payment Term.

v. If Single Pay option has been chosen by You, only one Premium is to be paid and no future Premiums are payable.

vi. We are not under any obligation to remind You about the premium due date, except as required by applicable regulations.

vii. The loading based on premium paying modes are mentioned below:

Premium frequency	Loading as a % of Premium
Yearly	NA
Half-yearly	1.25%
Monthly	2.50%

viii. You may pay Premium through any of the following modes:

a) Cash
b) Cheque
c) Demand Draft
d) Pay Order
e) Banker's cheque
f) Internet facility as approved by the Company from time to time
g) Electronic Clearing System / Direct Debit
h) Credit or Debit cards held in your name

ix. Amount and modalities will be subject to our rules and relevant legislation or regulation

x. Any payment made towards first or renewal premium is deemed to be received by Us only when it is received at any of Our branch offices or authorized collection points and after an official printed receipt is issued by Us.
xi. No person or individual or entity is authorized to collect cash or self-cheque or bearer cheque on Our behalf.
xii. Cheque or demand drafts must be drawn only in favour of ICICI Prudential Life Insurance Company Limited.
xiii. Please ensure that You mention the application number for the first premium deposit and the policy number for the renewal premiums on the cheque or demand draft.
xiv. Where Premiums have been remitted otherwise than in cash, the application of the Premiums received will be conditional on the realization of the proceeds of the instrument of payment, including electronic mode.
xv. If You suspend payment of premium for any reason whatsoever, We will not be held liable. In such an event, benefits, if any, will be available only in accordance with the Policy terms and conditions.
xvi. Premiums need to be paid only for the chosen premium payment term. Once premiums have been paid for the premium payment term, the policy benefits will continue for the term of the policy.

3. Maturity / Survival Benefit:

No benefit will be payable on maturity. At the end of the Policy Term, the Policy will automatically terminate and all rights, benefits and interests under the Policy will stand extinguished.

4. Grace Period

If you are unable to pay an instalment premium by the due date, you will be given a grace period of 15 days for payment of due instalment premium if You have chosen monthly frequency, and 30 days for payment of due instalment premium if You have chosen any other frequency, commencing from the premium due date. The life cover continues during the grace period. In case of death of Life Assured during the grace period, We will pay the applicable Death Benefit.

PART D

1. Free look Period (15 / 30 days refund policy)

You have an option to review the Policy following receipt of the Policy Document. If you are not satisfied with the terms and conditions of this Policy, please return the Policy Document to Us for cancellation with reasons within

i. 15 days from the date you received it, if your Policy is not purchased through Distance Mode.
ii. 30 days from the date you received it, if your Policy is an electronic policy or is purchased through Distance Mode

On cancellation of the Policy during the free look period, We will return the premium paid subject to the following deductions:

i. Proportionate risk premium for the period of cover
ii. Stamp duty under the Policy
iii. Expenses borne by the Company on medical examination, if any

The Policy shall terminate on payment of this amount and all rights, benefits and interests under this Policy will stand extinguished.

2. Paid-up Value

There is no paid-up value under this Policy.

3. Unexpired risk premium value

A. Single Pay:

i. Surrender means voluntary termination of the Policy by you.
ii. The Policy will terminate on surrender and all the rights / title and interest under the Policy shall stand extinguished.
iii. Unexpired risk premium value may be taxable as per the prevailing tax laws.
iv. The bases for computing Unexpired risk premium value factors will be reviewed from time to time and the factors applicable to existing business may be revised subject to the prior approval of the IRDAI.
v. Unexpired risk premium value will be calculated as given below.

Unexpired risk premium value = (Unexpired risk premium value Factor/ 100) * Single Premium

Unexpired risk premium value factors are given in Annexure I

B. Limited Pay:

i. Unexpired risk premium value, if any, will be payable if the policy holder voluntarily terminates the policy during the policy term
Or for lapsed policies on earlier of:

- Death of the Life Assured within the revival period, or
- At the end of the revival period.

Unexpired risk premium value = (Unexpired risk premium value Factor/100) X Annual Premium
Unexpired risk premium value Factors are given in Annexure I

ii. The Policy will terminate on payment of this amount and all the rights / title and interest under the Policy shall stand extinguished.
iii. Unexpired risk premium value may be taxable as per the prevailing tax laws.

C. Regular Pay:

No unexpired risk premium value is payable for Regular Pay policies.

4. Exclusions

For Waiver of Premium on Permanent Disability the following exclusions shall apply:

i. We will not be liable to provide the Waiver of Premium on Permanent Disability benefit if the Permanent Disability due to accident is directly or indirectly due to or caused, occasioned, accelerated or aggravated by, any one of the following:

- Attempted suicide or self-inflicted injuries while sane or insane, or whilst the Life Assured is under the influence of any narcotic substance or drug or intoxicating liquor except under the direction of a medical practitioner; or
- Engaging in aerial flights (including parachuting and skydiving) other than as a fare paying passenger or crew on a licensed passenger-carrying commercial aircraft operating on a regular scheduled route; or
- The Life Assured with criminal intent committing any breach of law; or
- Due to war, whether declared or not or civil commotion; or
- Engaging in hazardous sports / pastimes, i.e. taking part in (or practising for) boxing, caving, climbing, horse racing, jet skiing, martial arts, mountaineering, off piste skiing, pot holing, power boat racing, underwater diving, yacht racing or any race, trial or timed motor sport.
- PD due to accident must be caused by violent, external and visible means.

i. The accident shall result in bodily injury or injuries to the Life Assured independently of any other means. Such injury or injuries shall, within 180 days of the occurrence of the accident, directly and independently of any other means cause the PD of the Life Assured. In the event of PD of the Life Assured after 180 days of the occurrence of the accident, the Company shall not be liable to pay this benefit.

ii. The Company shall not be liable to pay this benefit in case PD of the Life Assured occurs after the date of termination of the policy.

5. Loan

We will not provide loans under this Policy.

6. Riders

Riders may be offered but only subject to prior approval of the Regulator.

7. Revival

A Policy which has lapsed for non-payment of premium within the grace period may be revived subject to underwriting and the following conditions:

a) The application for revival is made within 5 years from the due date of the first unpaid premium and before the termination date of the Policy. Revival will be based on the prevailing Board approved underwriting policy.
b) You furnish, at your own expense, satisfactory evidence of health as required by Us.
c) The arrears of Premiums together with interest at such rate as We may charge for late payment of premiums are paid. The interest rate applicable in July 2023 is 8.59% p.a. compounded half yearly.

d) The revival of the Policy may be on terms different from those applicable to the Policy before it lapsed for example, extra mortality premiums or charges may be applicable subject to our Board approved underwriting policy.
e) We reserve the right to not revive the Policy. In that case, only the premiums paid towards the revival of the policy shall be refunded without any interest.
f) The revival will take effect only if it is specifically communicated by Us to You.

8. To whom benefits are payable

Benefits are payable to the Policyholder or to the assignee(s) where an endorsement has been recorded in accordance with Section 38 of the Insurance Act, 1938, and as amended from time to time. In case of death of the Policyholder or assignee(s) as mentioned above, benefits are payable either to the Nominee(s) where a valid nomination has been registered by the Company (in accordance with section 39 of the Insurance Act, 1938, and as amended from time to time), or to the executors, administrators or other legal representatives who obtain representation to the estate of the Policyholder or to such person or persons as directed by a court of competent jurisdiction in India, limited at all times to the monies payable under this Policy.

If the Policyholder and Life Assured are different, then upon death of the Policyholder and subsequent intimation of the death with the Company, the policy shall vest on the Life Assured. Thereafter, the Life Assured shall become the Policyholder and will be entitled to all benefits and subject to all liabilities as per the terms and conditions of the policy. The Life Assured cum Policyholder can register due nomination as per Section 39 of the Insurance Act, 1938 as amended from time to time.

We hereby agree to pay the appropriate benefits under the Policy subject to:
a) Our satisfaction of the benefits having become payable on the happening of an event as per the Policy terms and conditions,
b) The title of the said person or persons claiming payment.

PART E – Not Applicable

PART F

General Conditions

1. Age

We have calculated the premiums under the Policy on the basis of the Age of the Life Assured as declared by You in the Proposal Form. In case if the age proof of the Life Assured was not submitted at the time of Proposal, You will be required to submit such an Age proof of the Life Assured acceptable to Us, and have the Age admitted.

If the Age of the life assured has been misstated, We will take one of the following actions:

a) If the Correct Age of the Life Assured makes him ineligible for this product, We will offer a suitable plan as per Our underwriting norms. If You do not wish to opt for the alternative plan or if it is not possible for Us to grant any other plan, We will cancel the Policy and refund the premiums paid (without interest) under the Policy after adjustment against the paid benefits. The Policy will terminate on the said payment.

b) If the Correct Age of the Life Assured makes him eligible for this Policy, revised Premium depending upon the Correct Age will be payable. Difference of premium from inception will be collected with interest, if age declared is higher and excess premium collected will be refunded without interest, if age is found to be lower.

The provisions of Section 45 of the Insurance Act, 1938, as amended from time to time shall be applicable.

2. Nomination

Nomination under the Policy will be governed by Section 39 of the Insurance Act, 1938, as amended from time to time. Please refer to Annexure II for details on this section.

3. Assignment

Assignment of the Policy will be governed by Section 38 of the Insurance Act, 1938, as amended from time to time. Please refer to Annexure III for details on this section.

4. Incontestability

Incontestability will be as per Section 45 of the Insurance Act, 1938, as amended from time to time. Please refer to Annexure IV for details on this section.

5. Misstatement & Fraud

Misstatement and Fraud will be as per Section 45 of the Insurance Act, 1938, as amended from time to time. Please refer to Annexure IV for details on this section.

The Policy is subject to the terms and conditions as mentioned in the Policy document and is governed by the Laws of India.

6. Communication address

Our communication address is:

Address: Customer Service Desk
ICICI Prudential Life Insurance Company Limited,
Ground Floor & Upper Basement,
Unit No. 1A & 2A, RahejaTipco Plaza,
Rani Sati Marg, Malad (East),
Mumbai- 400097
Maharashtra.

Telephone: 1860 266 7766
Facsimile: 022 4205 8222
E-mail: lifeline@iciciprulife.com

We expect You to immediately inform Us about any change in Your address or contact details.

7. Electronic transactions

All transactions carried out by You through Internet, electronic, call centres, tele-service operations, computer, automated machines network or through other means of communication will be valid and legally binding on Us as well as You.

This will be subject to the relevant guidelines and terms and conditions as may be specified by Us.

8. Jurisdiction

The Policy is subject to the terms and conditions as mentioned in the Policy document and is governed by the laws of India.

Indian courts shall have exclusive jurisdiction over all differences or disputes arising in relation to this Policy.

9. Legislative changes

All benefits payable under the Policy are subject to the tax laws and other financial enactments as they exist from time to time.

The Policy terms and conditions may be altered based on any future legislative or regulatory changes.

10. Payment of claim

For processing a death claim under this Policy, We will require the following documents (as may be relevant):

For natural deaths:

a) Claimant's Statement
b) Original Policy Document
c) Death Certificate of the Life Assured issued by the local municipal authority
d) Cancelled Cheque for processing electronic payment
e) Claimant's Photo Identity proof and address proof
f) Medical cause of the death certificate issued by the last treating/ last attending doctor, if any
g) Medical records (Admission notes, Discharge Summary/Death summary, test reports etc., if any
h) Any other documents or information as may be required by the Company for processing of the claim depending on the cause of the death.

For unnatural deaths:

a) Claimant's Statement
b) Original Policy Document
c) Death Certificate of the Life Assured issued by the local municipal authority
d) Cancelled Cheque for processing electronic payment
e) Claimant's Photo Identity proof & address proof
f) Post Mortem report & viscera/ chemical analysis report

g) FIR report, final police investigation report, police panchnama/ Inquest report, driving license
h) Any other documents or information as may be required by the Company for processing of the claim depending on the cause of the death.

For processing a maturity claim, survival benefit claims under this Policy, We will require the following documents

a) Payout mandate
b) Cancelled Cheque for processing electronic payment

Claim payments are made only in Indian currency in accordance with the prevailing Exchange control regulations and other relevant laws and regulations in India. In case the Claimant is unable to provide any or all of the above documents, in exceptional circumstances such as a natural calamity, the Company may at its own discretion conduct an investigation and may subsequently settle the claim.

11. Suicide

If the Life Assured, whether sane or insane, commits suicide within 12 months from the date of commencement of risk of this Policy, We will refund higher of 80% of the total premiums paid, if any till the date of death or unexpired risk premium value as available on the date of death, provided the policy is in force.

In the case of a revived Policy, if the Life Assured, whether sane or insane, commits suicide within 12 months of the date of revival of the Policy, higher of 80% of the total premiums paid, if any till date of death or unexpired risk premium value as available on date of death will be payable by Us.

The Policy will terminate on making such a payment and all rights, benefits and interests under the Policy will stand extinguished.

12. Issue of duplicate policy

We shall issue a duplicate of Policy document, on receipt of a written request for the same from You along with the necessary documents as may be required by Us and at such charges as may be applicable from time to time. The current charges for issuance of duplicate policy is Rs. 200. Freelook option is not available on issue of duplicate Policy document.

13. Amendment to policy document

Any variations, modifications or amendment of any terms of the Policy document shall be communicated to you in writing.

PART G

Grievance Redressal Mechanism & List of Ombudsman

1. Customer service

For any clarification or assistance You may contact Our advisor or call Our customer service representative (between 10.00 a.m. to 7.00 p.m., Monday to Saturday; excluding national holidays) on the numbers mentioned on the reverse of the Policy folder or on Our website: www.iciciprulife.com.

Alternatively, You may communicate with Us at any of our branches or the customer service desk whose details are mentioned in the Welcome Letter.

For updated contact details, We request You to regularly check Our website.

i. Grievance Redressal Officer:

If You do not receive any resolution from Us or if You are not satisfied with Our resolution, You may get in touch with Our designated grievance redressal officer (GRO) at gro@iciciprulife.com or 1860 266 7766.

Address:

ICICI Prudential Life Insurance Company Limited,
Ground Floor & Upper Basement,
Unit No. 1A & 2A, Raheja Tipco Plaza,
Rani Sati Marg, Malad (East),
Mumbai- 400097
Maharashtra.

For more details please refer to the "Grievance Redressal" section on www.iciciprulife.com

ii. Grievance Redressal Committee:

If You do not receive any resolution or if You are not satisfied with the resolution provided by the GRO, You may escalate the matter to Our internal grievance redressal committee at the address mentioned below:

ICICI Prudential Life Insurance Company Limited,
Ground Floor & Upper Basement,
Unit No. 1A & 2A, RahejaTipco Plaza,
Rani Sati Marg, Malad (East),
Mumbai- 400097
Maharashtra.

If you are not satisfied with the response or do not receive a response from us within 15 days, you may approach the Grievance Cell of the Insurance Regulatory and Development Authority of India (IRDAI) on the following contact details:

IRDAI Grievance Call Centre (IGCC) TOLL FREE NO:155255
Email ID: complaints@irda.gov.in

You can also register your complaint online at http://www.igms.irda.gov.in/
Address for communication for complaints by fax/paper:

Consumer Affairs Department
Insurance Regulatory and Development Authority of India
Sy.No.115/1, Financial District, Nanakramguda,
Gachibowli, Hyderabad – 500 032.

2. Insurance Ombudsman:

The Central Government has established an office of the Insurance Ombudsman for redressal of grievances with respect to life insurance policies. As per Insurance Ombudsman Rules, 2017 and Insurance Ombudsman (Amendment) Rules, 2021 the Ombudsman shall receive and consider complaints or alleging deficiency in performance required of an insurer (including its agents and intermediaries) or an insurance broker, on any of the following grounds:

a. delay in settlement of claims, beyond the time specified in the regulations, framed under the Insurance Regulatory and Development Authority of India Act, 1999;
b. any partial or total repudiation of claims, by the life insurer, General insurer or the health insurer;
c. disputes over premium paid or payable in terms of insurance policy;
d. misrepresentation of policy terms and conditions at any time in the policy document or policy contract;
e. legal construction of insurance policies in so far as the dispute relates to claim;
f. policy servicing related grievances against insurers, their agents and intermediaries;
g. issuance of life insurance policy, general insurance policy including health insurance policy which is not in conformity with proposal form submitted by the proposer:
h. non-issuance of insurance policy after receipt of premium ; in life insurance and general insurance including health insurance; and
i. any other matter arising from non-observance of or non-adherence to the provisions of any regulations made by the Authority with regard to protection of policyholders' interests or otherwise, or of any circular, guideline or instruction issued by the Authority, or of the terms and conditions of the policy contract, in so far as such matter relates to issues referred to in clauses (a) to (h).

Manner in which complaint to be made

(1) Any person who has a grievance against an insurer or insurance broker, may himself or through his legal heirs, nominee or assignee, make a complaint in writing to the Insurance Ombudsman within whose territorial jurisdiction the branch or office of the insurer or the insurer broker as the case may be complained against or the residential address or place of residence of the complainant is located.
(2) The complaint shall be in writing, duly signed or made by way of electronic mail or online through the website of the Council for Insurance Ombudsmen by the complainant or through his legal heirs, nominee or assignee and shall state clearly the name and address of the complainant, the name of the branch or office of the insurer against whom the complaint is made, the facts giving rise to the complaint, supported by documents, the nature and extent of the loss caused to the complainant and the relief sought from the Insurance Ombudsman.
(3) No complaint to the Insurance Ombudsman shall lie unless—
(a) the complainant has made a representation in writing or through electronic mail or online through website of the insurer or insurance broker concerned the insurer named in the complaint and—

i. either the insurer or insurance broker, as the case may be had rejected the complaint; or
ii. the complainant had not received any reply within a period of one month after the insurer or insurance broker, as the case may be received his representation; or
iii. the complainant is not satisfied with the reply given to him by the insurer or insurance broker, as the case may be;;

(b) The complaint is made within one year—
(i) after the order of the insurer rejecting the representation is received; or
(ii) after receipt of decision of the insurer or insurance broker, as the case may be which is not to the satisfaction of the complainant;
(iii) after expiry of a period of one month from the date of sending the written representation to the insurer or insurance broker, as the case may be if the insurer or insurance broker, as the case may be named fails to furnish reply to the complainant.

(4) The Ombudsman shall be empowered to condone the delay in such cases as he may consider necessary, after calling for objections of the insurer or insurance broker, as the case may be against the proposed condonation and after recording reasons for condoning the delay and in case the delay is condoned, the date of condonation of delay shall be deemed to be the date of filing of the complaint, for further proceedings under these rules.

(5) No complaint before the Insurance Ombudsman shall be maintainable on the same subject matter on which proceedings are pending before or disposed of by any court or consumer forum or arbitrator.

(6) The Council for Insurance Ombudsmen shall develop a complaints management system, which shall include an online platform developed for the purpose of online submission and tracking of the status of complaints made under rule 14

The Ombudsman shall not award compensation exceeding more than Rupees Thirty Lakhs (including relevant expenses, if any).

We have given below the details of the existing offices of the Insurance Ombudsman. We request You to regularly check our website at www.iciciprulife.com or the website of the IRDAI at www.irdai.gov.in for updated contact details.

Office of the Ombudsman	**Address**	**Contact Details**	**Areas of Jurisdiction**
AHMEDABAD	Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad - 380 001	Tel.:- 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat , Dadra & Nagar Haveli, Daman and Diu
BENGALURU	Office of Insurance Ombudsman, Jeevan Soudha	Tel No: 080 - 26652048 / 26652049	Karnataka

	Building, PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560078	Email: bimalokpal.bengaluru@cioins.co.in	
BHOPAL	Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003.	Tel.:- 0755-2769201, 2769202 Fax : 0755-2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh & Chhattisgarh
BHUBANESH WAR	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009.	Tel.:- 0674-2596455/2596461, Fax : 0674-2596429 Email: bimalokpal.bhubaneswar@cioins.co.in	Odisha
CHANDIGARH	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017	Tel.: 0172 - 2706196 / 2706468 Fax: 0172 – 2708274 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana(excluding Gurugram, Faridabad, Sonepat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.
CHENNAI	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor,	Tel.: 044 - 24333668 / 24335284 Fax: 044 – 24333664	Tamil Nadu, Tamil Nadu

	453, Anna Salai, Teynampet, Chennai – 600 018.	Email: bimalokpal.chennai@cioins.co.in	Puducherry Town and Karaikal (which are part of Puducherry).
DELHI	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002.	Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
ERNAKULAM	Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015.	Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
GUWAHATI	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001 (Assam).	Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-	Tel.: 040 - 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.

	Ka-Pool, Hyderabad - 500 004.		
JAIPUR	Office of the Insurance Ombudsman,Jeevan Nidhi – II Bldg., Gr. Floor,Bhawani Singh Marg,Jaipur - 302 005.	Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan
KOLKATA	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor,4, C.R. Avenue, Kolkatta - 700 072	Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001.	Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar,

			Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI	Office of the Insurance Ombudsman,3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054.	Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA	Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301.	Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.

PATNA	Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, North Wing Bailey Road, Patna 800001.	Tel.: 0612-2680952 Email: bimalokpal.patna@cioins.co.in	Bihar,Jharkhand
PUNE	Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030.	Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

Annexure I – Unexpired risk premium value factors

For Single Pay:

Policy Year \ Policy Term	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
1	30	30	30	35	35	40	40	40	40	40	40	40	40	40	40	40
2	25	25	25	35	35	35	35	35	35	35	35	35	35	35	40	40
3	15	20	20	30	30	35	35	35	35	35	35	35	35	35	40	40
4	5	15	15	25	30	30	30	35	35	35	35	35	35	35	40	40
5	0	5	5	20	25	30	30	30	30	35	35	35	35	35	40	40
6	0	0	5	15	20	25	25	30	30	35	35	35	35	35	40	40
7	0	0	0	5	15	20	20	25	30	30	35	35	35	35	40	40
8	0	0	0	0	5	15	15	20	25	30	30	35	35	35	40	40
9	0	0	0	0	0	5	10	15	20	25	30	30	35	35	40	40
10	0	0	0	0	0	0	5	10	15	20	25	25	30	35	35	35
11	0	0	0	0	0	0	0	5	10	15	25	25	30	30	35	35
12	0	0	0	0	0	0	0	0	5	10	15	20	25	30	35	35
13	0	0	0	0	0	0	0	0	0	5	10	15	20	25	30	35
14	0	0	0	0	0	0	0	0	0	0	5	5	15	20	25	30
15	0	0	0	0	0	0	0	0	0	0	0	5	10	15	20	25
16	0	0	0	0	0	0	0	0	0	0	0	0	5	10	20	20
17	0	0	0	0	0	0	0	0	0	0	0	0	0	5	10	15
18	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	10
19	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
20	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

For Limited pay:

As per Annexure VIII of the File and Use

Annexure II – Section 39 – Nomination by policyholder

Nomination of a life insurance Policy is as below in accordance with Section 39 of the Insurance Act, 1938, as amended from time to time. The extant provisions in this regard are as follows:

1. The policyholder of a life insurance on his own life may nominate a person or persons to whom money secured by the policy shall be paid in the event of his death.

2. Where the nominee is a minor, the policyholder may appoint any person to receive the money secured by the policy in the event of policyholder's death during the minority of the nominee. The manner of appointment to be laid down by the insurer.

3. Nomination can be made at any time before the maturity of the policy.

4. Nomination may be incorporated in the text of the policy itself or may be endorsed on the policy communicated to the insurer and can be registered by the insurer in the records relating to the policy.

5. Nomination can be cancelled or changed at any time before policy matures, by an endorsement or a further endorsement or a will as the case may be.

6. A notice in writing of Change or Cancellation of nomination must be delivered to the insurer for the insurer to be liable to such nominee. Otherwise, insurer will not be liable if a bonafide payment is made to the person named in the text of the policy or in the registered records of the insurer.

7. Fee to be paid to the insurer for registering change or cancellation of a nomination can be specified by the Authority through Regulations.

8. On receipt of notice with fee, the insurer should grant a written acknowledgement to the policyholder of having registered a nomination or cancellation or change thereof.

9. A transfer or assignment made in accordance with Section 38 shall automatically cancel the nomination except in case of assignment to the insurer or other transferee or assignee for purpose of loan or against security or its reassignment after repayment. In such case, the nomination will not get cancelled to the extent of insurer's or transferee's or assignee's interest in the policy. The nomination will get revived on repayment of the loan.

10. The right of any creditor to be paid out of the proceeds of any policy of life insurance shall not be affected by the nomination.

11. In case of nomination by policyholder whose life is insured, if the nominees die before the policyholder, the proceeds are payable to policyholder or his heirs or legal representatives or holder of succession certificate.

12. In case nominee(s) survive the person whose life is insured, the amount secured by the policy shall be paid to such survivor(s).

13. Where the policyholder whose life is insured nominates his
    a. parents or
    b. spouse or
    c. children or
    d. spouse and children
    e. or any of them

    the nominees are beneficially entitled to the amount payable by the insurer to the policyholder unless it is proved that policyholder could not have conferred such beneficial title on the nominee having regard to the nature of his title.

14. If nominee(s) die after the policyholder but before his share of the amount secured under the policy is paid, the share of the expired nominee(s) shall be payable to the heirs or legal representative of the nominee or holder of succession certificate of such nominee(s).

15. If policyholder dies after maturity but the proceeds and benefit of the policy has not been paid to him because of his death, his nominee(s) shall be entitled to the proceeds and benefit of the policy.

16. The provisions of Section 39 are not applicable to any life insurance policy to which Section 6 of Married Women's Property Act, 1874 applies or has at any time applied. Where nomination is intended to be made to spouse or children or spouse and children under Section 6 of MWP Act, it should be specifically mentioned on the policy. In such a case only, the provisions of Section 39 will not apply.

Disclaimer: This is a simplified version of Section 39 of the Insurance Act, 1938 as amended from time to time. The policyholders are advised to refer to The Insurance Act, 1938, as amended from time to time for complete and accurate details.

Annexure III – Section 38 – Assignment and Transfer of Insurance Policies

Assignment or transfer of a policy should be in accordance with Section 38 of the Insurance Act, 1938, as amended from time to time. The extant provisions in this regard are as follows:

1. This policy may be transferred/assigned, wholly or in part, with or without consideration.

2. An Assignment may be effected in a policy by an endorsement upon the policy itself or by a separate instrument under notice to the Insurer.

3. The instrument of assignment should indicate the fact of transfer or assignment and the reasons for the assignment or transfer, antecedents of the assignee and terms on which assignment is made.

4. The assignment must be signed by the transferor or assignor or duly authorized agent and attested by at least one witness.

5. The transfer of assignment shall not be operative as against an insurer until a notice in writing of the transfer or assignment and either the said endorsement or instrument itself or copy there of certified to be correct by both transferor and transferee or their duly authorised agents have been delivered to the insurer.

6. Fee to be paid for assignment or transfer can be specified by the Authority through Regulations.

7. On receipt of notice with fee, the insurer should Grant a written acknowledgement of receipt of notice. Such notice shall be conclusive evidence against the insurer of duly receiving the notice.

8. If the insurer maintains one or more places of business, such notices shall be delivered only at the place where the policy is being serviced.

9. The insurer may accept or decline to act upon any transfer or assignment or endorsement, if it has sufficient reasons to believe that it is
    a. not bonafide or
    b. not in the interest of the policyholder or
    c. not in public interest or
    d. is for the purpose of trading of the insurance policy.

10. Before refusing to act upon endorsement, the Insurer should record the reasons in writing and communicate the same in writing to Policyholder within 30 days from the date of policyholder giving a notice of transfer or assignment.

11. In case of refusal to act upon the endorsement by the Insurer, any person aggrieved by the refusal may prefer a claim to IRDAI within 30 days of receipt of the refusal letter from the Insurer.

12. The priority of claims of persons interested in an insurance policy would depend on the date on which the notices of assignment or transfer is delivered to the insurer; where there are more than one instruments of transfer or assignment, the priority will depend on dates of delivery of such notices. Any dispute in this regard as to priority should be referred to Authority.

13. Every assignment or transfer shall be deemed to be absolute assignment or transfer and the assignee or transferee shall be deemed to be absolute assignee or transferee, except
    a. where assignment or transfer is subject to terms and conditions of transfer or assignment OR
    b. where the transfer or assignment is made upon condition that
        i. the proceeds under the policy shall become payable to policyholder or nominee(s) in the event of assignee or transferee dying before the insured OR
        ii. the insured surviving the term of the policy

    Such conditional assignee will not be entitled to obtain a loan on policy or surrender the policy. This provision will prevail notwithstanding any law or custom having force of law which is contrary to the above position.

14. In other cases, the insurer shall, subject to terms and conditions of assignment, recognize the transferee or assignee named in the notice as the absolute transferee or assignee and such person
    a. shall be subject to all liabilities and equities to which the transferor or assignor was subject to at the date of transfer or assignment and
    b. may institute any proceedings in relation to the policy
    c. obtain loan under the policy or surrender the policy without obtaining the consent of the transferor or assignor or making him a party to the proceedings

    Disclaimer: This is a simplified version of Section 38 of the Insurance Act, 1938, as amended from time to time. The policyholders are advised to refer to The Insurance Act, 1938, as amended from time to time for complete and accurate details.

Annexure IV – Section 45 – Policy shall not be called in question on the ground of mis-statement after three years

Provisions regarding policy not being called into question in terms of Section 45 of the Insurance Act, 1938, as amended from time to time are as follows:

1. No Policy of Life Insurance shall be called in question on any ground whatsoever after expiry of 3 yrs from
    a) the date of issuance of policy or
    b) the date of commencement of risk or

c) the date of revival of policy or
d) the date of rider to the policy
whichever is later.

2. On the ground of fraud, a policy of Life Insurance may be called in question within 3 years from
   a) the date of issuance of policy or
   b) the date of commencement of risk or
   c) the date of revival of policy or
   d) the date of rider to the policy
   whichever is later.

   For this, the insurer should communicate in writing to the insured or legal representative or nominee or assignees of insured, as applicable, mentioning the ground and materials on which such decision is based.

3. Fraud means any of the following acts committed by insured or by his agent, with the intent to deceive the insurer or to induce the insurer to issue a life insurance policy:
   a) The suggestion, as a fact of that which is not true and which the insured does not believe to be true;
   b) The active concealment of a fact by the insured having knowledge or belief of the fact;
   c) Any other act fitted to deceive; and
   d) Any such act or omission as the law specifically declares to be fraudulent.

4. Mere silence is not fraud unless, depending on circumstances of the case, it is the duty of the insured or his agent keeping silence to speak or silence is in itself equivalent to speak.

5. No Insurer shall repudiate a life insurance Policy on the ground of Fraud, if the Insured / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the policyholder, if alive, or beneficiaries.

6. Life insurance Policy can be called in question within 3 years on the ground that any statement of or suppression of a fact material to expectancy of life of the insured was incorrectly made in the proposal or other document basis which policy was issued or revived or rider issued. For this, the insurer should communicate in writing to the insured or legal representative or nominee or assignees of insured, as applicable, mentioning the ground and materials on which decision to repudiate the policy of life insurance is based.

7. In case repudiation is on ground of mis-statement and not on fraud, the premium collected on policy till the date of repudiation shall be paid to the insured or legal representative or nominee or assignees of insured, within a period of 90 days from the date of repudiation.

8. Fact shall not be considered material unless it has a direct bearing on the risk undertaken by the insurer. The onus is on insurer to show that if the insurer had been aware of the said fact, no life insurance policy would have been issued to the insured.

9. The insurer can call for proof of age at any time if he is entitled to do so and no policy shall be deemed to be called in question merely because the terms of the policy are adjusted on subsequent

proof of age of life insured. So, this Section will not be applicable for questioning age or adjustment based on proof of age submitted subsequently.

Ishield_ICICI_Pru_iProtect_Smart_Annexure_V Policy_Document_Option_Life_Health

A Non-Linked Non-Par Life Individual pure risk premium product

Dear <Customer Name>,
This is your life insurance policy. It is a legal
Document. Please read it carefully.
We have highlighted some important points regarding your policy that you should keep in mind:

1. **YOUR POLICY DETAILS**
Name of your plan :<<Product Name>>
Policy Number : <Policy Number>
Mobile Number :<Mobile Number>
Email ID : <Email ID>
Person insured in this policy: <Name of Life Assured>
Sum Assured (Insurance Cover Amount) (in ‘) : <Amount>
Critical Illness Benefit (Critical Illness Cover Amount) (in ‘) : <Amount>
Premium Instalment (in ‘) : <Amount>
Payment frequency :<Payment Frequency>
Next premium due date : <Date>
You need to pay premiums for: PPT in years
Policy Term : <Policy Term> years
Policy end date: <Date of Maturity>

In case of any discrepancies in the above details please inform us immediately.

About the Advisor

Name : <Advisor Name>
Code / License Number : <Advisor Code>
Contact Number : <Advisor Contact>
Address : <Advisor address>

You may contact your advisor for any queries you have or any clarifications that you require in relation to the Policy Terms and conditions or any policy servicing requirements.

2. **YOUR FREE LOOK PERIOD**
You have an option to review the policy within <15/30> days from the date you receive it. In this period, if you are not satisfied with the policy terms and conditions, you can return the policy to us with reasons for cancellation. We will refund the premium paid after deduction of Stamp duty, proportionate risk premium and expenses for medical tests if any.

3. MAKING A CLAIM
You can contact Us on 1-860-266-7766 for any claims to be made under the policy and we will assist the claimant through the entire process.
In case of any queries or clarifications required, please feel free to contact your advisor or reach us at any of our service centres mentioned below. We will be happy to assist you. Warm regards,

<<< Authorised Signatory >>>

Visit us at

<<< Designation >>> www.iciciprulife.com

Write to us at: Email us at: Customer Service Helpline
ICICI Prudential Life Insurance Co. Ltd. lifeline@iciciprulife.com 1860 266 7766
Ground Floor & Upper Basement,
Unit No. 1A & 2A, Raheja Tipco Plaza,
Rani Sati Marg, Malad (East),Mumbai- 400097
Maharashtra.

ICICI Prudential Life Insurance Co. Ltd. Registered Address: ICICI Pru Life Towers,
1089, Appasaheb Marathe Marg, Prabhadevi, Mumbai-400025.
Reg No:105. Insurance is the subject matter of the solicitation.
Unique Identification Number as specified by IRDAI 105N151V08

Policy Schedule ICICI Pru iProtect Smart (UIN: 105N151V08)
(This is a Non-Linked Non-Par Life Individual pure risk premium product)

Policy Preamble

This Policy is the evidence of a contract between ICICI Prudential Life Insurance Company Limited (Us/We/Company) and the Policyholder (You) referred to below.

We have issued this Policy on the basis of the details provided by You in the Proposal Form submitted along with the required declarations, personal statement, applicable medical reports, the first premium deposit and any other information and documentation which constitute evidence of the insurability of the Life Assured for the issuance of the Policy.

We agree to provide the benefits set out in this Policy subject to its terms and conditions.

Policy Schedule

Name of the Life Assured:

Address:	Category: Medical/Non-Medical		
Date of Birth:	Age (Years):	Gender: M/F/T	Age Admitted: Y/N

Name of the Policyholder:

Policy No:	Benefit Option:

Policy Issue Date:	Date of Maturity:
Policy Acceptance Date:	Policy Term in years:

Premium Payment Term in years:	Periodicity of payment of premium (premium frequency):
Premium payment option:	Accelerated Critical Illness Benefit Term in years:
Total instalment premium (Rs.):	Accelerated Critical Illness Benefit (Rs.):
Sum Assured (Rs.):	Policy sourced by Distance Mode: Y/N
Accidental Death Benefit (Rs.):	Accidental Death Benefit Term in years:

Death Benefit Payout Option:	Due date of last premium payable:

Option	Sum Assured payable
Lump sum	
Income	
Increasing Income	

Nominee(s) Name	Gender	Nominee's Age	Percentage Share	Relationship to the Life Assured	Appointee Name [in case the Nominee is a minor]	Appointee's Gender	Appointee's Age	Relationship of the appointee with the Life Assured

Goods and Services Tax and/or cesses would be charged extra, as applicable.

Policy Schedule, terms and conditions of the Policy and the endorsements by Us, if any, shall form an integral part of this contract and shall be binding on Us and You.

The Policy shall stand cancelled by Us, without any further notice, in the event of dishonour of the first premium deposit.

Please immediately inform Us about any change in address or contact details.

Signed for and on behalf of the ICICI Prudential Life Insurance Company Limited, at Head Office, Mumbai on ……. (Issue Date)

<<<Authorised Signatory >>>

<<<Designation>>>

Version ……

Stamp duty of Rs. …….. (Rupees …….Only) paid by Pay order, vide receipt no. …… dated ……...

This is an output of a digitally signed print file

Please examine the policy and approach Us immediately in case of any discrepancies.

PART B

Definitions

1. Age means age at last birthday.
2. Accident means a sudden, unforeseen and involuntary event caused by external, visible and violent means.
3. Accelerated Critical Illness Benefit (ACI Benefit) means the benefit, which is payable upon the Life Assured being diagnosed on first occurrence of any of the covered 34 Critical Illnesses.
4. Annualized Premium means the premium amount payable in a year chosen by the policyholder, excluding the taxes, rider premiums, underwriting extra premiums and loadings for modal premiums, if any.
5. Appointee means the person appointed by You to receive the benefits payable under the Policy till Your Nominee is a minor.
6. Death Benefit means the benefit, which is payable on death or diagnosis of Terminal Illness as specified in the Policy Document.
7. Death Benefit Payout Option is the manner in which the Nominee receives the Death Benefit payable under the Policy.
8. Claimant means the person entitled to receive the Policy benefits and includes You, the nominee, the assignee, the legal heir, the legal representative(s) or the holder(s) of succession certificate as the case may be.
9. Date of commencement of risk is later of Policy Issue Date or Policy Acceptance Date
10. Date of Maturity means the date specified in the Policy Schedule on which the term of the Policy ends.
11. Distance Mode means every activity of solicitation (including lead generation) and sale of insurance products through the following modes: (i) voice mode, which includes telephone-calling (ii) short messaging service (SMS) (iii) electronic mode which includes e-mail, internet and interactive television (DTH) (iv) physical mode which includes direct postal mail and newspaper and magazine inserts and (v) solicitation through any means of communication other than in person.
12. Hospital A hospital means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) and the said act Or complies with all minimum criteria as under:
    i. has qualified nursing staff under its employment round the clock;
    ii. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
    iii. has qualified medical practitioner(s) in charge round the clock;
    iv. has a fully equipped operation theatre of its own where surgical procedures are carried out;
    v. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;
13. Insured event is the event on the happening of which, benefits under Your policy become payable.
14. Life Assured means the person named in the Policy Schedule on whose life the Policy has been issued.
15. Limited Pay means premiums need to be paid regularly for a limited portion of the Policy Term.
16. Medical Practitioner is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of licence The Medical Practitioner should neither be the insured person(s) himself nor related to the insured person(s) by blood or marriage.
17. Nominee means the person named in the Policy Schedule who has been nominated by You to receive benefits in respect of this Policy.

18. Policy means the contract of Insurance entered into between You and Us as evidenced by the "Policy document".
19. Policy Acceptance Date means the date as specified in the Policy Schedule, from which the policy was effected.
20. Policy document means this document, the Proposal Form, the Policy Schedule and any additional information/document(s) provided to Us in respect of the Proposal Form, and any endorsement issued by Us.
21. Policy Issue Date means the date as specified in the Policy Schedule.
22. Policyholder or the Proposer or You or Your means the owner of the Policy at any point of time.
23. Policy Term means the period between the Policy Acceptance Date and the Date of Maturity specified in the Policy Schedule.
24. Policy Schedule means the policy schedule and any endorsements attached to and forming part of this Policy.
25. Premium means the instalment premium in case of Regular Pay and Limited Pay or single premium in case of Single Pay specified in the Policy Schedule which is payable/has been received under the Policy.
26. Pre-existing Disease means any condition, ailment, injury or disease:
    i. that is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the Company or its revival or
    ii. For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy or its revival.
27. Premium Payment Term means the period specified in the Policy Schedule during which Premium is payable.
28. Proposal Form means a form to be completed by You for availing an insurance policy, and to furnish all Material information required by Us to assess risk and to decline or to undertake the risk, and in the event of acceptance of risk, to determine the rates, advantages, terms and conditions of a cover to be granted.
    Explanation: "Material" shall mean and include all important, essential and relevant information that enables Us to take an informed decision while underwriting the risk.
29. Regulator means the authority that has regulatory jurisdiction and powers over Us. Currently the Regulator is the Insurance Regulatory and Development Authority of India (IRDAI).
30. Regular Pay means premiums need to be paid regularly throughout the Policy term.
31. Revival of the Policy means restoration of Policy benefits.
32. Revival period means the period of five consecutive years from the due date of the first unpaid premium and before the termination date of the Policy, during which period You are entitled to revive the policy.
33. Sum Assured means the amount specified in the Policy Schedule.
34. Surrender means complete withdrawal/termination of the Policy by You.
35. Total Premiums Paid means the total of all premiums received, excluding any extra premium, any rider premium and taxes.
36. Unexpired risk premium value means an amount, if any, that becomes payable in case of surrender or discontinuance of premium in single/ limited pay policies in accordance with the terms and conditions of the Policy.
37. You or Your means the Policyholder of the Policy at any point of time.
38. We or Us or Our or Company means ICICI Prudential Life Insurance Company Limited.

PART C

1. Benefits available under the policy:

1.1 Death Benefit

We shall pay the Death Benefit as per the Death Benefit Payout Option stated on Your Policy Schedule upon diagnosis of Terminal Illness or death of the Life Assured whichever is earlier provided the Policy is in force as on the date of diagnosis of Terminal Illness or the date of death of the Life Assured. A Life Assured shall be regarded as "Terminally Ill" only if that Life Assured is diagnosed as suffering from a condition which, in the opinion of two independent Medical Practitioners, specializing in treatment of such illness, is highly likely to lead to death within 6 months. The terminal illness must be diagnosed and confirmed by Medical Practitioners registered with Indian Medical Association and approved by Us. We reserve the right for independent assessment of the Terminal Illness. Death Benefit would be as per the below table:

Premium Payment Option	Death Benefit
Regular Pay and Limited Pay	Higher of 7 times the annualized premium or 105% of the total premiums received up to the date of death or the sum assured as stated on your policy schedule to be paid on death.

a. The Death Benefit will reduce by the extent of the ACI Benefit claim paid if the Death Benefit is higher than the Critical Illness Benefit. ACI Benefit is as explained in section 1.3 below.
b. The Policy shall terminate upon payment of the Death Benefit.
c. The Death Benefit amount may be taxable as per the prevailing tax laws.

1.2 Waiver of Premium on Permanent Disability due to accident

a. Upon the diagnosis of Permanent Disability (as defined below) of the Life Insured which arises due to an Accident, We shall waive all future premiums payable for all benefits under the Policy during the remaining Premium Payment Term of the Policy provided the Policy is in force as on the date of diagnosis of Permanent Disability of the Life Assured.

   The Policy will continue for the Death Benefit & Accelerated Critical Illness Benefit.

b. For the purpose of this benefit, " Permanent Disability" means the inability of the Life Assured to perform at least 3 of the following 6 activities of daily work:

   - Mobility: The ability to walk a distance of 200 meters on flat ground.
   - Bending: The ability to bend or kneel to touch the floor and straighten up again and the ability to get into a standard saloon car, and out again.
   - Climbing: The ability to climb up a flight of 12 stairs and down again, using the handrail if needed.
   - Lifting: The ability to pick up an object weighing 2kg at table height and hold for 60 seconds before replacing the object on the table.
   - Writing: The manual dexterity to write legibly using a pen or pencil, or type using a desktop personal computer keyboard.

- Blindness: The permanent and irreversible loss of sight to the extent that even when tested with the use of visual aids, vision is measured at 3/60 or worse in the better eye using a Snellen eye chart.

c. Provided that the disability should have lasted for at least 180 days without interruption from the date of disability and must be deemed permanent by a Company empanelled Medical Practitioner. In the event of death of the insured within the above period, the policy shall terminate on payment of applicable benefits and all rights, benefits and interests under the policy shall stand extinguished.

d. In case of incidences covered under accidental Permanent Disability as well as Critical Illness, benefits shall be paid out under both the options.

1.3 Accelerated Critical Illness (ACI) Benefit

a. We shall pay the ACI Benefit upon the Life Assured being diagnosed on first occurrence of any of the covered 34 Critical Illnesses defined below within ACI Benefit term, provided the Policy is in force as on the date of diagnosis of Critical Illness of the Life Assured.
b. Once ACI Benefit is triggered,
   - If ACI Benefit is less than the Death Benefit the policy will continue with a reduced Death Benefit by the extent of ACI Benefit paid. Premium payment on account of ACI Benefit will cease after payout of ACI Benefit. The future premiums for Death Benefit will reduce proportionately.
   - If ACI Benefit is equal to the Death Benefit the policy will terminate.
   - The benefit is payable irrespective of the actual expenses incurred by the policyholder.
c. In case of Angioplasty: ACI Benefit payable is subject to a maximum of Rs. 5,00,000. On payment of Angioplasty,
   - The policy will continue for other covered CIs with ACI Benefit reduced by Angioplasty payout and future premiums for ACI benefit reduced proportionately and
   - The Policy will continue with Death Benefit reduced by Angioplasty payout, and future premiums for Death Benefit will reduce proportionately.
d. In case of incidences covered under accidental Permanent Disability as well as Critical Illness, benefits shall be paid out under both the options.
e. In case no ACI Benefit is triggered within the ACI Benefit term, then ACI Benefit will terminate and premiums corresponding to it will not be payable. However You would be required to pay premiums for all other Benefits to keep the policy in force.

<u>Waiting Period for Critical Illness benefit</u>

a. The benefit shall not apply or be payable in respect of any Critical Illness advice was recommended by or received from a Physician, or which first manifested itself or was contracted during the first six months from the date of commencement of risk or three months from the policy revival date where the policy has lapsed for more than three months.
b. In the event of occurrence of any of the scenarios mentioned in ‘a’ above, or in case of a death claim, where it is established that the Life Assured was diagnosed to have any one of the covered critical illness during the waiting period for which a critical illness claim could have been made, the Company will refund the premiums corresponding to the ACI Benefit from date of commencement of risk of the policy or from the date of revival as applicable and the ACI Benefit will terminate with immediate effect.

c. No waiting period applies where the Critical Illness arises due to an Accident.

For the purpose of the ACI Benefit, "Critical Illness" means any of the following listed illnesses or procedures:

1. Cancer of Specified Severity:

A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.

The following are excluded –

1. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN-2 and CIN-3.
2. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
3. Malignant melanoma that has not caused invasion beyond the epidermis;
4. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
5. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
6. Chronic lymphocytic leukaemia less than RAI stage 3
7. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
8. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

2. Open Chest CABG:

The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

Excluded are:
Angioplasty and/or any other intra-arterial procedures

3. Myocardial Infarction (First Heart Attack of Specified Severity):

The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

1. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
2. New characteristic electrocardiogram changes

3. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded:

1. Other acute Coronary Syndromes
2. Any type of angina pectoris
3. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

4. Heart Valve Surgery (Open Heart Replacement or Repair of Heart Valves):

The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

5. Surgery to aorta

The actual undergoing of major surgery to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches.

6. Cardiomyopathy

An impaired function of the heart muscle, unequivocally diagnosed as Cardiomyopathy by a Registered Medical Practitioner who is a cardiologist, and which results in permanent physical impairment to the degree of New York Heart Association classification Class III or Class IV, or its equivalent, based on the following classification criteria:
Class III - Marked functional limitation. Affected patients are comfortable at rest but performing activities involving less than ordinary exertion will lead to symptoms of congestive cardiac failure.
Class IV - Inability to carry out any activity without discomfort. Symptoms of congestive cardiac failure are present even at rest. With any increase in physical activity, discomfort will be experienced. The Diagnosis of Cardiomyopathy has to be supported by echographic findings of compromised ventricular performance. Irrespective of the above, Cardiomyopathy directly related to alcohol or drug abuse is excluded.

7. Primary (Idiopathic) Pulmonary hypertension

An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

The NYHA Classification of Cardiac Impairment are as follows:

a. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
b. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

8. Angioplasty

Coronary Angioplasty is defined as percutaneous coronary intervention by way of balloon angioplasty with or without stenting for treatment of the narrowing or blockage of minimum 50 % of one or more major coronary arteries. The intervention must be determined to be medically necessary by a cardiologist and supported by a coronary angiogram (CAG).

Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery.

Diagnostic angiography or investigation procedures without angioplasty/stent insertion are excluded.

9. Blindness

Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident.

The Blindness is evidenced by:
a. corrected visual acuity being 3/60 or less in both eyes or ;
b. the field of vision being less than 10 degrees in both eyes.

The diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure.

10. End stage Lung Failure (Chronic Lung Disease):

End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:
1. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
2. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
3. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO2 < 55mmHg); and
4. Dyspnea at rest.

11. End stage liver failure (Chronic Liver Disease):

Permanent and irreversible failure of liver function that has resulted in all three of the following:

1. Permanent jaundice; and
2. Ascites; and
3. Hepatic encephalopathy.

Liver failure secondary to drug or alcohol abuse is excluded.

12. Kidney Failure Requiring Regular Dialysis:

End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

13. Major Organ/ Bone Marrow Transplant

The actual undergoing of a transplant of:

i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.
iii. The following are excluded:
    a. Other stem-cell transplants
    b. Where only islets of langerhans are transplanted

14. Apallic Syndrome:

Universal necrosis of the brain cortex, with the brain stem intact. Diagnosis must be definitely confirmed by a Registered Medical practitioner who is also a neurologist holding such an appointment at an approved hospital. This condition must be documented for at least one (1) month.

15. Benign Brain Tumour:

Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.

This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.

1. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
2. Undergone surgical resection or radiation therapy to treat the brain tumor.

The following conditions are excluded:

Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord.

16. Brain Surgery

The actual undergoing of surgery to the brain, under general anaesthesia, during which a Craniotomy is performed. Burr hole and brain surgery as a result of an accident is excluded. The procedure must be considered necessary by a qualified specialist and the benefit shall only be payable once corrective surgery has been carried out.

17. Coma of Specified Severity:

A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

- no response to external stimuli continuously for at least 96 hours;
- life support measures are necessary to sustain life; and
- permanent neurological deficit which must be assessed at least 30 days after the onset of the coma

The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

18. Major Head Trauma

Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.

The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word “permanent” shall mean beyond the scope of recovery with current medical knowledge and technology.

The Activities of Daily Living are:

1. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
2. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
3. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
4. Mobility: the ability to move indoors from room to room on level surfaces;
5. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
6. Feeding: the ability to feed oneself once food has been prepared and made available.

The following are excluded:

1. Spinal cord injury

19. Permanent Paralysis of Limbs

Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

20. Stroke resulting in permanent symptoms

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.
The following are excluded:

- Transient ischemic attacks (TIA)
- Traumatic injury of the brain
- Vascular disease affecting only the eye or optic nerve or vestibular functions.

21. Alzheimer's Disease

Alzheimer's (presenile dementia) disease is a progressive degenerative disease of the brain, characterised by diffuse atrophy throughout the cerebral cortex with distinctive histopathological changes. It affects the brain, causing symptoms like memory loss, confusion, communication problems, and general impairment of mental function, which gradually worsens leading to changes in personality.
Deterioration or loss of intellectual capacity, as confirmed by clinical evaluation and imaging tests, arising from Alzheimer's disease, resulting in progressive significant reduction in mental and social functioning, requiring the continuous supervision of the Insured Person. The diagnosis must be supported by the clinical confirmation of a Neurologist and supported by Our appointed Medical Practitioner.
The disease must result in a permanent inability to perform three or more Activities of daily living with Loss of Independent Living" or must require the need of supervision and permanent presence of care staff due to the disease. This must be medically documented for a period of at least 90 days

The following conditions are however not covered:
a. neurosis or neuropsychiatric symptoms without imaging evidence of Alzheimer's Disease
b. alcohol related brain damage; and
c. any other type of irreversible organic disorder/dementia not associated with Alzheimer's Disease

The Activities of Daily Living are:

i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
iv. Mobility: the ability to move indoors from room to room on level surfaces;
v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
vi. Feeding: the ability to feed oneself once food has been prepared and made available

22. Motor Neurone Disease with permanent symptoms

Motor neurone disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anteriorhorn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

23. Multiple Sclerosis with Persisting Symptoms

The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

1. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
2. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

Other causes of neurological damage such as SLE are excluded.

24. Muscular Dystrophy

Diagnosis of muscular dystrophy by a Registered Medical Practitioner who is a neurologist based on three (3) out of four (4) of the following conditions:
(a) Family history of other affected individuals;
(b) Clinical presentation including absence of sensory disturbance, normal cerebro-spinal fluid and mild tendon reflex reduction;
(c) Characteristic electromyogram; or
(d) Clinical suspicion confirmed by muscle biopsy.

The condition must result in the inability of the Life Assured to perform (whether aided or unaided) at least three (3) of the six (6) 'Activities of Daily Living' as defined, for a continuous period of at least six (6) months.

25. Parkinson's Disease

Unequivocal Diagnosis of Parkinson's Disease by a Registered Medical Practitioner who is a neurologist where the condition:
(a) cannot be controlled with medication;
(b) shows signs of progressive impairment; and
(c) Activities of Daily Living assessment confirms the inability of the Insured to perform at least three (3) of the Activities of Daily Living as defined in the Policy, either with or without the use of mechanical equipment, special devices or other aids or adaptations in use for disabled persons.

Drug-induced or toxic causes of Parkinson's disease are excluded.

26. Poliomyelitis

The occurrence of Poliomyelitis where the following conditions are met:
1. Poliovirus is identified as the cause and is proved by Stool Analysis,
2. Paralysis of the limb muscles or respiratory muscles must be present and persist for at least 3 months.

27. Loss of Independent Existence

The insured person is physically incapable of performing at least three (3) of the "Activities of Daily Living" as defined below (either with or without the use of mechanical equipment, special devices or other aids or adaptations in use for disabled persons) for a continuous period of at least six (6) months, signifying a permanent and irreversible inability to perform the same. For the purpose of this definition, the word "permanent" shall mean beyond the hope of recovery with current medical knowledge and technology. The Diagnosis of Loss of Independent Existence must be confirmed by a Registered Doctor Who is a specialist.

Only Life Insured with Insurance Age between 18 and 74 on first diagnosis is eligible to receive a benefit under this illness.

Activities of Daily Living:

1. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
2. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
3. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
4. Mobility: the ability to move indoors from room to room on level surfaces;
5. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
6. Feeding: the ability to feed oneself once food has been prepared and made available.

28. Loss of Limbs

The physical separation of two or more limbs, at or above the wrist or ankle level limbs as a result of injury or disease. This will include medically necessary amputation necessitated by injury or disease. The separation has to be permanent without any chance of surgical correction. Loss of Limbs resulting directly or indirectly from self-inflicted injury, alcohol or drug abuse is excluded.

29. Deafness

Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means "the loss of hearing to the extent that the loss is greater than 90decibels across all frequencies of hearing" in both ears.

30. Loss of Speech

Total and irrecoverable loss of the ability to speak as a result of injury or disease to the Vocal Cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by an Ear, Nose, and Throat (ENT) specialist.

31. Medullary Cystic Disease

Medullary Cystic Disease where the following criteria are met:

a) the presence in the kidney of multiple cysts in the renal medulla accompanied by the presence of tubular atrophy and interstitial fibrosis;
b) clinical manifestations of anaemia, polyuria, and progressive deterioration in kidney function; and
c) the Diagnosis of Medullary Cystic Disease is confirmed by renal biopsy.

Isolated or benign kidney cysts are specifically excluded from this benefit.

32. Systematic lupus Eryth. with Renal Involvement

Multi-system, autoimmune disorder characterized by the development of auto-antibodies, directed against various self-antigens. For purposes of the definition of "Critical Illness", SLE is restricted to only those forms of systemic lupus erythematosus, which involve the kidneys and are characterized as Class III, Class IV, Class V or Class VI lupus nephritis under the Abbreviated International Society of Nephrology/Renal Pathology Society (ISN/RPS) classification of lupus nephritis (2003) below based on renal biopsy. Other forms such as discoid lupus, and those forms with only hematological and joint involvement are specifically excluded.

Abbreviated ISN/RPS classification of lupus nephritis (2003):

Class I - Minimal mesangial lupus nephritis

Class II - Mesangial proliferative lupus nephritis

Class III - Focal lupus nephritis

Class IV - Diffuse segmental (IV-S) or global (IV-G) lupus nephritis

Class V - Membranous lupus nephritis

ClassVI - Advanced sclerosing lupus nephritis the final diagnosis must be confirmed by a certified doctor specialising in Rheumatology and Immunology.

33. Third degree burns (Major Burns):

There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

34. Aplastic Anaemia

Irreversible persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least two (2) of the following:
(a) Blood product transfusion;
(b) Marrow stimulating agents;
(c) Immunosuppressive agents; or
(d) Bone marrow transplantation.
The Diagnosis of aplastic anaemia must be confirmed by a bone marrow biopsy. Two out of the following three values should be present:
- Absolute Neutrophil count of 500 per cubic millimetre or less;
- Absolute Reticulocyte count of 20,000 per cubic millimetre or less; and
- Platelet count of 20,000 per cubic millimetre or less.

1.4 Life Stage Protection

You can choose to increase the Death Benefit at the key milestones of marriage and child birth/ adoption of child, provided no claim has been admitted for any benefits under the policy and the policy is in force.

The Death Benefit can be increased without any medicals on any one or all of the below events during the term of the Policy. This feature is available to a Life Assured underwritten as a standard life at the time of inception of the Policy per the Board Approved Underwriting Policy.

Event	Additional Death Benefit (percentage of original Sum Assured)	Subject to maximum additional Death Benefit
Marriage	50%	Rs. 50,00,000
Birth / Legal adoption of 1st child	25%	Rs. 25,00,000
Birth / Legal adoption of 2nd child	25%	Rs. 25,00,000

On exercising the option, You will have to pay an additional premium for the additional Sum Assured for the outstanding term of the policy based on your then age. Hence the future premium payable by You on exercising this option will be the sum of original premium and additional premium.

No fee is chargeable for this option.

This feature is available only with Regular premium payment option. Such increase in sum assured is only applicable to base death benefit. The ACI Benefit and AD Benefit will remain unchanged. Premium will be recalculated based on the increased Death Sum Assured and outstanding policy term. This is subject to:

1. Minimum policy term (which is 5 years) available at the time of the exercising this feature.
2. The Life Assured being less than 50 years of age at the time of the event.

Such increase needs to be exercised within 6 months of the event and will be effective from the next policy anniversary. The additional premium will also be payable from next policy anniversary.

1.5 Death Benefit Payout Options

The Death Benefit will be payable as per one of the below options chosen by You at the inception of Your policy and mentioned in Your Policy Schedule.

1. Lump Sum Option – Entire Death Benefit amount is payable as lump sum.
2. Income Option – 10% of the Death Benefit amount is payable every year for 10 years. This will be payable in equal monthly instalments in advance at the rate of 0.83333% of Death Benefit amount.
   The beneficiary can also advance the first year's income as a lump sum. The monthly income will then continue from the subsequent month for next 9 years advance at the rate of 0.80% of Death Benefit amount.
3. Lump sum and Income – The part of the Death Benefit amount to be paid out as lump sum is chosen at inception. The balance Death Benefit amount will be paid out in equal monthly instalments in advance at the rate of 0.83333% per month over 10 years.
4. Increasing Income Option – Benefit amount is payable in monthly instalments for 10 years starting with 10% of the benefit amount per annum in the first year. The income amount will increase at 10% p.a. simple interest every year thereafter.

For options 2, 3, and 4, You or the nominee as the case may be, will have an option to take the discounted value of the future payouts anytime during the payout term by informing Us of this decision in writing. The present value will be derived using discount rate of 4% p.a..

1.6 You have an option to add Accidental Death(AD) Benefit anytime during the policy term except in last 5 years, for which the following conditions apply:

- It can be opted by Regular Pay Policies only
- The policy must be in-force at the time of adding the Benefit
- There must not have been any claim in the policy till the time of opting of AD Benefit
- The availability of the AD benefit will be subject to underwriting, as per the prevailing board approved underwriting policy
- If AD Benefit is chosen, it will commence from subsequent policy anniversary for the remaining policy term or till age 80, whichever is lower. You will have to pay an additional premium corresponding to this Benefit. Life Assured's then age must be less than or equal to 55 years(age last birthday)
- The Benefit once added, cannot be removed.

1.7 Smart Exit Benefit

You have an option to cancel the Policy and receive Smart Exit Benefit, equal to Total Premiums Paid under the Policy. No additional premium is payable to avail this option.

The following conditions are applicable for availing Smart Exit benefit:

- The Sum Assured in the policy at inception is ₹ 6,000,000 or above.
- This option can be exercised in any policy year greater than 25 but not during the last 5 policy years, provided the age of the life assured is 60 years or more at the time of exercise.
- The Policy is in-force with all due premiums paid at the time of exercising this option.
- No claim for any of the underlying benefits has been registered and is under evaluation/ or accepted/ or paid/ being paid on the Policy.

The Policy shall terminate on payment of this benefit (if exercised) and all rights, benefits and interests under this Policy will stand extinguished. You can either opt for Smart Exit Benefit or Unexpired Risk Premium Value as per Clause 3, Part D, i.e. you cannot avail both the benefits simultaneously.

Where Life Stage Protection options has been exercised, Total Premiums Paid includes Premium paid for each tranche of additional sum assured purchased. In case the benefit term for additional benefit(s) (which are benefits other than as mentioned in Part C, Clause 1.1 and 1.2) has expired at the time of exercise of Smart Exit Benefit, then Total Premiums Paid shall exclude the Premium Paid towards such additional benefit(s).

2. Premium payment:

i. You are required to pay Premiums on the due dates and for the amount mentioned in the Policy Schedule.

ii. The grace period for payment of premium is 15 days for monthly frequency of premium payment and 30 days for other frequencies of premium payment. In case of occurrence of the covered events during the grace period, We will pay the benefits as per the terms and conditions of the Policy.

iii. If any premium instalment is not paid within the grace period then the Policy shall lapse and all cover under the Policy will cease.

iv. You are required to pay Premiums for the entire Premium Payment Term.

v. If One Pay option has been chosen by You, only one Premium is to be paid and no future Premiums are payable.

vi. We are not under any obligation to remind You about the premium due date, except as required by applicable regulations.

vii. The loading based on premium paying modes are mentioned below:

Premium frequency	Loading as a % of Premium
Yearly	NA
Half-yearly	1.25%
Monthly	2.50%

viii. You may pay Premium through any of the following modes:

a) Cash
b) Cheque
c) Demand Draft
d) Pay Order
e) Banker's cheque
f) Internet facility as approved by the Company from time to time
g) Electronic Clearing System / Direct Debit
h) Credit or Debit cards held in your name

ix. Amount and modalities will be subject to our rules and relevant legislation or regulation

x. Any payment made towards first or renewal premium is deemed to be received by Us only when it is received at any of Our branch offices or authorized collection points and after an official printed receipt is issued by Us.

xi. No person or individual or entity is authorized to collect cash or self-cheque or bearer cheque on Our behalf.

xii. Cheque or demand drafts must be drawn only in favour of ICICI Prudential Life Insurance Company Limited.
xiii. Please ensure that You mention the application number for the first premium deposit and the policy number for the renewal premiums on the cheque or demand draft.
xiv. Where Premiums have been remitted otherwise than in cash, the application of the Premiums received will be conditional on the realization of the proceeds of the instrument of payment, including electronic mode.
xv. If You suspend payment of premium for any reason whatsoever, We will not be held liable. In such an event, benefits, if any, will be available only in accordance with the Policy terms and conditions.
xvi. Premiums need to be paid only for the chosen premium payment term. Once premiums have been paid for the premium payment term, the policy benefits will continue for the term of the policy.

3. Maturity/Survival Benefit:

No benefit will be payable upon the maturity of the Policy. At the end of the Policy Term, the Policy will automatically terminate and all rights, benefits and interests under the Policy will stand extinguished.

4. Grace Period

If you are unable to pay an instalment premium by the due date, you will be given a grace period of 15 days for payment of due instalment premium if You have chosen monthly frequency, and 30 days for payment of due instalment premium if You have chosen any other frequency, commencing from the premium due date. The life cover continues during the grace period. In case of death of Life Assured during the grace period, We will pay the applicable Death Benefit.

PART D

1. Free look Period (15 / 30 days refund policy)

You have an option to review the Policy following receipt of the Policy Document. If you are not satisfied with the terms and conditions of this Policy, please return the Policy Document to Us for cancellation with reasons within

i. 15 days from the date you received it, if your Policy is not purchased through Distance Mode
ii. 30 days from the date you received it, if your Policy is an electronic policy or is purchased through Distance Mode

On cancellation of the Policy during the freelook period, We will return the premium paid subject to the following deductions:

i. Proportionate risk premium for the period of cover
ii. Stamp duty under the Policy
iii. Expenses borne by the Company on medical examination, if any

The Policy shall terminate on payment of this amount and all rights, benefits and interests under this Policy will stand extinguished.

2. Paid-up Value

There is no paid-up value under this Policy.

3. Unexpired risk premium value

For Limited Pay policies:

i. Unexpired risk premium value, if any, will be payable if the policy holder voluntarily terminates the policy during the policy term

Or for lapsed policies on earlier of:

i. Death of the Life Assured within the revival period, or
ii. At the end of the revival period.

Unexpired risk premium value = (Unexpired risk premium value factor/100) X Annual Premium
Unexpired risk premium value factors are given in Annexure I

ii. The Policy will terminate on payment of this amount and all the rights / title and interest under the Policy shall stand extinguished.
iii. Unexpired risk premium value may be taxable as per the prevailing tax laws.

For Regular Pay policies:
No unexpired risk premium value is payable for Regular Pay policies.

4. Exclusions

4.1. For Waiver of Premium on Permanent Disability the following exclusions shall apply:

i. We will not be liable to provide the Waiver of Premium on Permanent Disability benefit if the Permanent Disability is directly or indirectly due to or caused, occasioned, accelerated or aggravated by, any one of the following:

- Attempted suicide or self-inflicted injuries while sane or insane, or whilst the Life Assured is under the influence of any narcotic substance or drug or intoxicating liquor except under the direction of a medical practitioner; or
- Engaging in aerial flights (including parachuting and skydiving) other than as a fare paying passenger or crew on a licensed passenger-carrying commercial aircraft operating on a regular scheduled route; or
- The Life Assured with criminal intent committing any breach of law; or
- Due to war, whether declared or not or civil commotion; or
- Engaging in hazardous sports / pastimes, i.e. taking part in (or practising for) boxing, caving, climbing, horse racing, jet skiing, martial arts, mountaineering, off piste skiing, pot holing, power boat racing, underwater diving, yacht racing or any race, trial or timed motor sport.
- PD due to accident must be caused by violent, external and visible means.

ii. The accident shall result in bodily injury or injuries to the Life Assured independently of any other means. Such injury or injuries shall, within 180 days of the occurrence of the accident, directly and independently of any other means cause the PD of the Life Assured. In the event of PD of the Life Assured after 180 days of the occurrence of the accident, the Company shall not be liable to pay this benefit.

iii. The Company shall not be liable to pay this benefit in case CPD of the Life Assured occurs after the date of termination of the policy.

4.2. For ACI Benefit the following exclusions apply:

We will not be liable to pay any ACI Benefit in respect of any listed condition arising directly or indirectly from, though, in consequence of or aggravated by any of the following:

a) Pre-Existing Conditions or conditions connected to a Pre-Existing Condition will be excluded. Pre-existing Disease means any condition, ailment, injury or disease:
   i. that is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the Company or its revival or
   ii. For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy or its revival.
b) Existence of any Sexually Transmitted Disease (STD) and its related complications
c) Self-inflicted injury, suicide, insanity and deliberate participation of the life insured in an illegal or criminal act with criminal intent.
d) Use of intoxicating drugs / alcohol / solvent, taking of drugs except under the direction of a qualified medical practitioner.
e) War – whether declared or not, civil commotion, breach of law with criminal intent, invasion, hostilities (whether war is declared or not), rebellion, revolution, military or usurped power or wilful participation in acts of violence.
f) Aviation other than as a fare paying passenger or crew in a commercial licensed aircraft.
g) Taking part in any act of a criminal nature with criminal intent.
h) Treatment for injury or illness caused by avocations / activities such as hunting, mountaineering, steeple-chasing, professional sports, racing of any kind, scuba diving, aerial sports, activities such as hand-gliding, ballooning, deliberate exposure to exceptional danger.
i) Radioactive contamination due to nuclear accident.
j) Failure to seek or follow medical advice, the Life assured has delayed medical treatment in order to circumvent the waiting period or other conditions and restriction applying to this policy.
k) Any treatment of a donor for the replacement of an organ.
l) Any illness due to a congenital defect or disease which has manifested or was diagnosed before the Insured attains aged 17.

5. Loan

We will not provide loans under this Policy.

6. Riders

Riders may be offered but only subject to prior approval of the Regulator.

7. Revival

A Policy which has lapsed for non-payment of premium within the grace period may be revived subject to underwriting and the following conditions:

a) The application for revival is made within 5 years from the due date of the first unpaid premium and before the termination date of the Policy. Revival will be based on the prevailing Board approved underwriting policy.
b) You furnish, at your own expense, satisfactory evidence of health as required by Us.
c) The arrears of Premiums together with interest at such rate as We may charge for late payment of premiums are paid. The interest rate applicable in July 2023 is 8.59% p.a. compounded half yearly.
d) The revival of the Policy may be on terms different from those applicable to the Policy before it lapsed for example, extra mortality premiums or charges may be applicable subject to our Board approved underwriting policy.
e) We reserve the right to not revive the Policy. In that case, only the premiums paid towards the revival of the Policy shall be refunded without any interest.
f) For ACI Benefit, a waiting period of 3 months will be applicable for any revivals after 3 months from the due date of the first unpaid premium. No waiting period will be applicable for any revival within 3 months of the due date of the first unpaid premium.
g) The revival will take effect only if it is specifically communicated by Us to You.

8. To whom benefits are payable

Benefits are payable to the Policyholder or to the assignee(s) where an endorsement has been recorded in accordance with Section 38 of the Insurance Act, 1938, and as amended from time to time. In case of death of the Policyholder or assignee(s) as mentioned above, benefits are payable either to the Nominee(s) where a valid nomination has been registered by the Company (in accordance with section 39 of the Insurance Act, 1938, and as amended from time to time), or to the executors, administrators or other legal representatives who obtain representation to the estate of the Policyholder or to such person or persons as directed by a court of competent jurisdiction in India, limited at all times to the monies payable under this Policy.

If the Policyholder and Life Assured are different, then upon death of the Policyholder and subsequent intimation of the death with the Company, the policy shall vest on the Life Assured. Thereafter, the Life Assured shall become the Policyholder and will be entitled to all benefits and subject to all liabilities as per the terms and conditions of the policy. The Life Assured cum Policyholder can register due nomination as per Section 39 of the Insurance Act, 1938 as amended from time to time.

We hereby agree to pay the appropriate benefits under the Policy subject to:

a) Our satisfaction of the benefits having become payable on the happening of an event as per the Policy terms and conditions,

b) The title of the said person or persons claiming payment.

PART E: Not Applicable

PART F

General Conditions

1. Age

We have calculated the premiums under the Policy on the basis of the Age of the Life Assured as declared by You in the Proposal Form. In case if the age proof of the Life Assured was not submitted at the time of Proposal, You will be required to submit such an Age proof of the Life Assured acceptable to Us, and have the Age admitted.

If the Age of the life assured has been misstated, We will take one of the following actions:

a) If the Correct Age of the Life Assured makes him ineligible for this product, We will offer a suitable plan as per Our underwriting norms. If You do not wish to opt for the alternative plan or if it is not possible for Us to grant any other plan, We will cancel the Policy and refund the premiums paid (without interest) under the Policy after adjustment against the paid benefits. The Policy will terminate on the said payment.

b) If the Correct Age of the Life Assured makes him eligible for this Policy, revised Premium depending upon the Correct Age will be payable. Difference of premium from inception will be collected with interest, if age declared is higher and excess premium collected will be refunded without interest, if age is found to be lower.

The provisions of Section 45 of the Insurance Act, 1938, as amended from time to time shall be applicable.

2. Nomination

Nomination under the Policy will be governed by Section 39 of the Insurance Act, 1938, as amended from time to time. Please refer to Annexure II for details on this section.

3. Assignment

Assignment of the Policy will be governed by Section 38 of the Insurance Act, 1938, as amended from time to time. Please refer to Annexure III for details on this section.

4. Incontestability

Incontestability will be as per Section 45 of the Insurance Act, 1938, as amended from time to time. Please refer to Annexure IV for details on this section.

5. Misstatement & Fraud

Misstatement and Fraud will be as per Section 45 of the Insurance Act, 1938, as amended from time to time. Please refer to Annexure IV for details on this section.

The Policy is subject to the terms and conditions as mentioned in the Policy document and is governed by the Laws of India.

6. Communication address

Our communication address is:

Address: Customer Service Desk
ICICI Prudential Life Insurance Company Limited,
Ground Floor & Upper Basement,
Unit No. 1A & 2A, RahejaTipco Plaza,
Rani Sati Marg, Malad (East),
Mumbai- 400097
Maharashtra.

Telephone: 1860 266 7766
Facsimile: 022 4205 8222
E-mail: lifeline@iciciprulife.com

We expect You to immediately inform Us about any change in Your address or contact details.

7. Electronic transactions

All transactions carried out by You through Internet, electronic, call centres, tele-service operations, computer, automated machines network or through other means of communication will be valid and legally binding on Us as well as You.

This will be subject to the relevant guidelines and terms and conditions as may be specified by Us.

8. Jurisdiction

The Policy is subject to the terms and conditions as mentioned in the Policy document and is governed by the laws of India.

Indian courts shall have exclusive jurisdiction over all differences or disputes arising in relation to this Policy

9. Legislative changes

All benefits payable under the Policy are subject to the tax laws and other financial enactments as they exist from time to time.

The Policy terms and conditions may be altered based on any future legislative or regulatory changes.

10. Payment of claim

For processing a death claim under this Policy, We will require the following documents (as may be relevant):

For natural deaths:

a) Claimant's Statement
b) Original Policy Document
c) Death Certificate of the Life Assured issued by the local municipal authority
d) Cancelled Cheque for processing electronic payment
e) Claimant's Photo Identity proof and address proof
f) Medical cause of the death certificate issued by the last treating/ last attending doctor, if any
g) Medical records (Admission notes, Discharge Summary/Death summary, test reports etc., if any
h) Any other documents or information as may be required by the Company for processing of the claim depending on the cause of the death.

For unnatural deaths:

a) Claimant's Statement
b) Original Policy Document
c) Death Certificate of the Life Assured issued by the local municipal authority
d) Cancelled Cheque for processing electronic payment
e) Claimant's Photo Identity proof & address proof
f) Post Mortem report & viscera/ chemical analysis report
g) FIR report, final police investigation report, police panchnama/ Inquest report, driving license
h) Any other documents or information as may be required by the Company for processing of the claim depending on the cause of the death.

Claim payments are made only in Indian currency in accordance with the prevailing Exchange control regulations and other relevant laws and regulations in India. In case the Claimant is unable to provide any or all of the above documents, in exceptional circumstances such as a natural calamity, the Company may at its own discretion conduct an investigation and may subsequently settle the claim.

11. Suicide

If the Life Assured, whether sane or insane, commits suicide within 12 months from the date of commencement of risk of this Policy, We will refund higher of 80% of the total premiums paid, if any till the date of death or unexpired risk premium value as available on date of death, provided the policy is in force.

In the case of a revived Policy, if the Life Assured, whether sane or insane, commits suicide within 12 months of the date of revival of the Policy, higher of 80% of the total premiums paid, if any till date of death or unexpired risk premium value as available on date of death will be payable by Us.

The Policy will terminate on making such a payment and all rights, benefits and interests under the Policy will stand extinguished.

12. Issue of duplicate policy

We shall issue a duplicate of Policy document, on receipt of a written request for the same from You along with the necessary documents as may be required by Us and at such charges as may be applicable from time to time. The current charges for issuance of duplicate policy is Rs. 200. Freelook option is not available on issue of duplicate Policy document.

13. Amendment to policy document

Any variations, modifications or amendment of any terms of the Policy document shall be communicated to you in writing.

PART G

Grievance Redressal Mechanism & List of Ombudsman

1. Customer service

For any clarification or assistance You may contact Our advisor or call Our customer service representative (between 10.00 a.m. to 7.00 p.m., Monday to Saturday; excluding national holidays) on the numbers mentioned on the reverse of the Policy folder or on Our website: www.iciciprulife.com.

Alternatively, You may communicate with Us at any of our branches or the customer service desk whose details are mentioned in the Welcome Letter.

For updated contact details, We request You to regularly check Our website.

i. Grievance Redressal Officer:

If You do not receive any resolution from Us or if You are not satisfied with Our resolution, You may get in touch with Our designated grievance redressal officer (GRO) at gro@iciciprulife.com or 1860 266 7766.

Address:

ICICI Prudential Life Insurance Company Limited,
Ground Floor & Upper Basement,
Unit No. 1A & 2A, Raheja Tipco Plaza,
Rani Sati Marg, Malad (East),
Mumbai- 400097
Maharashtra.

For more details please refer to the “Grievance Redressal” section on www.iciciprulife.com

ii. Grievance Redressal Committee:

If You do not receive any resolution or if You are not satisfied with the resolution provided by the GRO, You may escalate the matter to Our internal grievance redressal committee at the address mentioned below:

ICICI Prudential Life Insurance Company Limited,
Ground Floor & Upper Basement,
Unit No. 1A & 2A, RahejaTipco Plaza,
Rani Sati Marg, Malad (East),
Mumbai- 400097
Maharashtra.

If you are not satisfied with the response or do not receive a response from us within 15 days, you may approach the Grievance Cell of the Insurance Regulatory and Development Authority of India (IRDAI) on the following contact details:

IRDAI Grievance Call Centre (IGCC) TOLL FREE NO:155255
Email ID: complaints@irda.gov.in

You can also register your complaint online at http://www.igms.irda.gov.in/
Address for communication for complaints by fax/paper:

Consumer Affairs Department
Insurance Regulatory and Development Authority of India
Sy.No.115/1, Financial District, Nanakramguda,
Gachibowli, Hyderabad – 500 032.

2. Insurance Ombudsman:

The Central Government has established an office of the Insurance Ombudsman for redressal of grievances with respect to life insurance policies. As per Insurance Ombudsman Rules, 2017 and Insurance Ombudsman (Amendment) Rules, 2021 the Ombudsman shall receive and consider complaints or alleging deficiency in performance required of an insurer (including its agents and intermediaries) or an insurance broker, on any of the following grounds:

a. delay in settlement of claims, beyond the time specified in the regulations, framed under the Insurance Regulatory and Development Authority of India Act, 1999;
b. any partial or total repudiation of claims, by the life insurer, General insurer or the health insurer;
c. disputes over premium paid or payable in terms of insurance policy;
d. misrepresentation of policy terms and conditions at any time in the policy document or policy contract;
e. legal construction of insurance policies in so far as the dispute relates to claim;
f. policy servicing related grievances against insurers, their agents and intermediaries;
g. issuance of life insurance policy, general insurance policy including health insurance policy which is not in conformity with proposal form submitted by the proposer:

h. non-issuance of insurance policy after receipt of premium ; in life insurance and general insurance including health insurance; and

i. any other matter arising from non-observance of or non-adherence to the provisions of any regulations made by the Authority with regard to protection of policyholders' interests or otherwise, or of any circular, guideline or instruction issued by the Authority, or of the terms and conditions of the policy contract, in so far as such matter relates to issues referred to in clauses (a) to (h).

Manner in which complaint to be made

(1) Any person who has a grievance against an insurer or insurance broker, may himself or through his legal heirs, nominee or assignee, make a complaint in writing to the Insurance Ombudsman within whose territorial jurisdiction the branch or office of the insurer or the insurer broker as the case may be complained against or the residential address or place of residence of the complainant is located.

(2) The complaint shall be in writing, duly signed or made by way of electronic mail or online through the website of the Council for Insurance Ombudsmen by the complainant or through his legal heirs, nominee or assignee and shall state clearly the name and address of the complainant, the name of the branch or office of the insurer against whom the complaint is made, the facts giving rise to the complaint, supported by documents, the nature and extent of the loss caused to the complainant and the relief sought from the Insurance Ombudsman.

(3) No complaint to the Insurance Ombudsman shall lie unless—

(a) the complainant has made a representation in writing or through electronic mail or online through website of the insurer or insurance broker concerned the insurer named in the complaint and—

i. either the insurer or insurance broker, as the case may be had rejected the complaint; or

ii. the complainant had not received any reply within a period of one month after the insurer or insurance broker, as the case may be received his representation; or

iii. the complainant is not satisfied with the reply given to him by the insurer or insurance broker, as the case may be;;

(b) The complaint is made within one year—

(i) after the order of the insurer rejecting the representation is received; or

(ii) after receipt of decision of the insurer or insurance broker, as the case may be which is not to the satisfaction of the complainant;

(iii) after expiry of a period of one month from the date of sending the written representation to the insurer or insurance broker, as the case may be if the insurer or insurance broker, as the case may be named fails to furnish reply to the complainant.

(4) The Ombudsman shall be empowered to condone the delay in such cases as he may consider necessary, after calling for objections of the insurer or insurance broker, as the case may be against the proposed condonation and after recording reasons for condoning the delay and in case the delay is condoned, the date of condonation of delay shall be deemed to be the date of filing of the complaint, for further proceedings under these rules.

(5) No complaint before the Insurance Ombudsman shall be maintainable on the same subject matter on which proceedings are pending before or disposed of by any court or consumer forum or arbitrator.

(6) The Council for Insurance Ombudsmen shall develop a complaints management system, which shall include an online platform developed for the purpose of online submission and tracking of the status of complaints made under rule 14

The Ombudsman shall not award compensation exceeding more than Rupees Thirty Lakhs (including relevant expenses, if any).

We have given below the details of the existing offices of the Insurance Ombudsman. We request You to regularly check our website at www.iciciprulife.com or the website of the IRDAI at www.irdai.gov.in for updated contact details.

Office of the Ombudsman	Address	Contact Details	Areas of Jurisdiction
AHMEDABAD	Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad - 380 001	Tel.:- 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat , Dadra & Nagar Haveli, Daman and Diu
BENGALURU	Office of Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560078	Tel No: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka
BHOPAL	Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003.	Tel.:- 0755-2769201, 2769202 Fax : 0755-2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh & Chhattisgarh
BHUBANESH WAR	Office of the Insurance Ombudsman, 62, Forest park,	Tel.:- 0674-2596455/2596461, Fax : 0674-2596429	Odisha

	Bhubneshwar – 751 009.	Email: bimalokpal.bhubaneswar@cioins.co.in	
CHANDIGARH	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017	Tel.: 0172 - 2706196 / 2706468 Fax: 0172 – 2708274 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana(excluding Gurugram, Faridabad, Sonepat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.
CHENNAI	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai – 600 018.	Tel.: 044 - 24333668 / 24335284 Fax: 044 – 24333664 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Tamil Nadu Puducherry Town and Karaikal (which are part of Puducherry).
DELHI	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002.	Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
ERNAKULAM	Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015.	Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.

GUWAHATI	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001 (Assam).	Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004.	Tel.: 040 - 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR	Office of the Insurance Ombudsman,Jeevan Nidhi – II Bldg., Gr. Floor,Bhawani Singh Marg,Jaipur - 302 005.	Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan
KOLKATA	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor,4, C.R. Avenue, Kolkatta - 700 072	Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj,	Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad,

	Lucknow - 226 001.		Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI	Office of the Insurance Ombudsman,3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054.	Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA	Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar,	Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar,

	U.P-201301.		Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA	Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, North Wing Bailey Road, Patna 800001.	Tel.: 0612-2680952 Email: bimalokpal.patna@cioins.co.in	Bihar,Jharkhand
PUNE	Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030.	Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

Annexure I – Unexpired risk premium value factors

For Limited pay:

As per Annexure VIII of the File and Use

Annexure II – Section 39 – Nomination by policyholder

Nomination of a life insurance Policy is as below in accordance with Section 39 of the Insurance Act, 1938, as amended from time to time. The extant provisions in this regard are as follows:

1. The policyholder of a life insurance on his own life may nominate a person or persons to whom money secured by the policy shall be paid in the event of his death.

2. Where the nominee is a minor, the policyholder may appoint any person to receive the money secured by the policy in the event of policyholder's death during the minority of the nominee. The manner of appointment to be laid down by the insurer.

3. Nomination can be made at any time before the maturity of the policy.

4. Nomination may be incorporated in the text of the policy itself or may be endorsed on the policy communicated to the insurer and can be registered by the insurer in the records relating to the policy.

5. Nomination can be cancelled or changed at any time before policy matures, by an endorsement or a further endorsement or a will as the case may be.

6. A notice in writing of Change or Cancellation of nomination must be delivered to the insurer for the insurer to be liable to such nominee. Otherwise, insurer will not be liable if a bonafide payment is made to the person named in the text of the policy or in the registered records of the insurer.

7. Fee to be paid to the insurer for registering change or cancellation of a nomination can be specified by the Authority through Regulations.

8. On receipt of notice with fee, the insurer should grant a written acknowledgement to the policyholder of having registered a nomination or cancellation or change thereof.

9. A transfer or assignment made in accordance with Section 38 shall automatically cancel the nomination except in case of assignment to the insurer or other transferee or assignee for purpose of loan or against security or its reassignment after repayment. In such case, the nomination will not get cancelled to the extent of insurer's or transferee's or assignee's interest in the policy. The nomination will get revived on repayment of the loan.

10. The right of any creditor to be paid out of the proceeds of any policy of life insurance shall not be affected by the nomination.

11. In case of nomination by policyholder whose life is insured, if the nominees die before the policyholder, the proceeds are payable to policyholder or his heirs or legal representatives or holder of succession certificate.

12. In case nominee(s) survive the person whose life is insured, the amount secured by the policy shall be paid to such survivor(s).

13. Where the policyholder whose life is insured nominates his
    a. parents or
    b. spouse or
    c. children or
    d. spouse and children
    e. or any of them

    the nominees are beneficially entitled to the amount payable by the insurer to the policyholder unless it is proved that policyholder could not have conferred such beneficial title on the nominee having regard to the nature of his title.

14. If nominee(s) die after the policyholder but before his share of the amount secured under the policy is paid, the share of the expired nominee(s) shall be payable to the heirs or legal representative of the nominee or holder of succession certificate of such nominee(s).

15. If policyholder dies after maturity but the proceeds and benefit of the policy has not been paid to him because of his death, his nominee(s) shall be entitled to the proceeds and benefit of the policy.

16. The provisions of Section 39 are not applicable to any life insurance policy to which Section 6 of Married Women's Property Act, 1874 applies or has at any time applied. Where nomination is intended to be made to spouse or children or spouse and children under Section 6 of MWP Act, it should be specifically mentioned on the policy. In such a case only, the provisions of Section 39 will not apply.

Disclaimer: This is a simplified version of Section 39 of the Insurance Act, 1938, as amended from time to time. The policyholders are advised to refer to The Insurance Act, 1938, as amended from time to time for complete and accurate details.

Annexure III – Section 38 – Assignment and Transfer of Insurance Policies

Assignment or transfer of a policy should be in accordance with Section 38 of the Insurance Act, 1938, as amended from time to time. The extant provisions in this regard are as follows:

1. This policy may be transferred/assigned, wholly or in part, with or without consideration.

2. An Assignment may be effected in a policy by an endorsement upon the policy itself or by a separate instrument under notice to the Insurer.

3. The instrument of assignment should indicate the fact of transfer or assignment and the reasons for the assignment or transfer, antecedents of the assignee and terms on which assignment is made.

4. The assignment must be signed by the transferor or assignor or duly authorized agent and attested by at least one witness.

5. The transfer of assignment shall not be operative as against an insurer until a notice in writing of the transfer or assignment and either the said endorsement or instrument itself or copy there of

certified to be correct by both transferor and transferee or their duly authorised agents have been delivered to the insurer.

6. Fee to be paid for assignment or transfer can be specified by the Authority through Regulations.

7. On receipt of notice with fee, the insurer should Grant a written acknowledgement of receipt of notice. Such notice shall be conclusive evidence against the insurer of duly receiving the notice.

8. If the insurer maintains one or more places of business, such notices shall be delivered only at the place where the policy is being serviced.

9. The insurer may accept or decline to act upon any transfer or assignment or endorsement, if it has sufficient reasons to believe that it is
    a. not bonafide or
    b. not in the interest of the policyholder or
    c. not in public interest or
    d. is for the purpose of trading of the insurance policy.

10. Before refusing to act upon endorsement, the Insurer should record the reasons in writing and communicate the same in writing to Policyholder within 30 days from the date of policyholder giving a notice of transfer or assignment.

11. In case of refusal to act upon the endorsement by the Insurer, any person aggrieved by the refusal may prefer a claim to IRDAI within 30 days of receipt of the refusal letter from the Insurer.
12. The priority of claims of persons interested in an insurance policy would depend on the date on which the notices of assignment or transfer is delivered to the insurer; where there are more than one instruments of transfer or assignment, the priority will depend on dates of delivery of such notices. Any dispute in this regard as to priority should be referred to Authority.

13. Every assignment or transfer shall be deemed to be absolute assignment or transfer and the assignee or transferee shall be deemed to be absolute assignee or transferee, except
    a. where assignment or transfer is subject to terms and conditions of transfer or assignment OR
    b. where the transfer or assignment is made upon condition that
        i. the proceeds under the policy shall become payable to policyholder or nominee(s) in the event of assignee or transferee dying before the insured OR
        ii. the insured surviving the term of the policy

    Such conditional assignee will not be entitled to obtain a loan on policy or surrender the policy. This provision will prevail notwithstanding any law or custom having force of law which is contrary to the above position.

14. In other cases, the insurer shall, subject to terms and conditions of assignment, recognize the transferee or assignee named in the notice as the absolute transferee or assignee and such person
    a. shall be subject to all liabilities and equities to which the transferor or assignor was subject to at the date of transfer or assignment and
    b. may institute any proceedings in relation to the policy
    c. obtain loan under the policy or surrender the policy without obtaining the consent of the transferor or assignor or making him a party to the proceedings

Disclaimer: This is a simplified version of Section 38 of the Insurance Act, 1938, as amended from time to time. The policyholders are advised to refer to The Insurance Act, 1938, as amended from time to time for complete and accurate details.

Annexure IV – Section 45 – Policy shall not be called in question on the ground of mis-statement after three years

Provisions regarding policy not being called into question in terms of Section 45 of the Insurance Act, 1938, as amended from time to time are as follows:

1. No Policy of Life Insurance shall be called in question on any ground whatsoever after expiry of 3 yrs from
   a) the date of issuance of policy or
   b) the date of commencement of risk or
   c) the date of revival of policy or
   d) the date of rider to the policy

   whichever is later.

2. On the ground of fraud, a policy of Life Insurance may be called in question within 3 years from
   a) the date of issuance of policy or
   b) the date of commencement of risk or
   c) the date of revival of policy or
   d) the date of rider to the policy

   whichever is later.

   For this, the insurer should communicate in writing to the insured or legal representative or nominee or assignees of insured, as applicable, mentioning the ground and materials on which such decision is based.

3. Fraud means any of the following acts committed by insured or by his agent, with the intent to deceive the insurer or to induce the insurer to issue a life insurance policy:
   a) The suggestion, as a fact of that which is not true and which the insured does not believe to be true;
   b) The active concealment of a fact by the insured having knowledge or belief of the fact;
   c) Any other act fitted to deceive; and
   d) Any such act or omission as the law specifically declares to be fraudulent.

4. Mere silence is not fraud unless, depending on circumstances of the case, it is the duty of the insured or his agent keeping silence to speak or silence is in itself equivalent to speak.

5. No Insurer shall repudiate a life insurance Policy on the ground of Fraud, if the Insured / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the policyholder, if alive, or beneficiaries.

6. Life insurance Policy can be called in question within 3 years on the ground that any statement of or suppression of a fact material to expectancy of life of the insured was incorrectly made in the proposal or other document basis which policy was issued or revived or rider issued. For this, the

insurer should communicate in writing to the insured or legal representative or nominee or assignees of insured, as applicable, mentioning the ground and materials on which decision to repudiate the policy of life insurance is based.

7. In case repudiation is on ground of mis-statement and not on fraud, the premium collected on policy till the date of repudiation shall be paid to the insured or legal representative or nominee or assignees of insured, within a period of 90 days from the date of repudiation.

8. Fact shall not be considered material unless it has a direct bearing on the risk undertaken by the insurer. The onus is on insurer to show that if the insurer had been aware of the said fact, no life insurance policy would have been issued to the insured.

9. The insurer can call for proof of age at any time if he is entitled to do so and no policy shall be deemed to be called in question merely because the terms of the policy are adjusted on subsequent proof of age of life insured. So, this Section will not be applicable for questioning age or adjustment based on proof of age submitted subsequently.

Ishield_ICICI_Pru_iProtect_Smart_Annexure_V Policy_Document_Option_Life_Plus

A Non-Linked Non-Par Life Individual pure risk premium product

Dear <Customer Name>,
This is your life insurance policy. It is a legal
Document. Please read it carefully.
We have highlighted some important points regarding your policy that you should keep in mind:

1. **YOUR POLICY DETAILS**
Name of your plan :<<Product Name>>
Policy Number : <Policy Number>
Mobile Number :<Mobile Number>
Email ID : <Email ID>
Person insured in this policy: <Name of Life Assured>
Sum Assured (Insurance Cover Amount) (in ‘) : <Amount>
Accidental Death Benefit (Accidental Death Cover) (in ‘): <Amount>
Accidental Death Benefit Term in years: <ADB Term> years
Premium Instalment (in ‘) : <Amount>
Payment frequency :<Payment Frequency>
Next premium due date : <Date>
You need to pay premiums for: <PPT> years
Policy Term : <Policy Term> years
Policy end date: <Date of Maturity>

In case of any discrepancies in the above details please inform us immediately.

About the Advisor

Name : <Advisor Name>
Code / License Number : <Advisor Code>
Contact Number : <Advisor Contact>
Address : <Advisor address>

You may contact your advisor for any queries you have or any clarifications that you require in relation to the Policy Terms and conditions or any policy servicing requirements.

2. **YOUR FREE LOOK PERIOD**
You have an option to review the policy within <15/30> days from the date you receive it. In this period, if you are not satisfied with the policy terms and conditions, you can return the policy to us with reasons for cancellation. We will refund the premium paid after deduction of Stamp duty, proportionate risk premium and expenses for medical tests if any.

3. MAKING A CLAIM
You can contact Us on 1-860-266-7766 for any claims to be made under the policy and we will assist the claimant through the entire process.
In case of any queries or clarifications required, please feel free to contact your advisor or reach us at any of our service centres mentioned below. We will be happy to assist you. Warm regards,

<<< Authorised Signatory >>>
<<< Designation >>>

Visit us at
www.iciciprulife.com

Write to us at:
ICICI Prudential Life Insurance Co. Ltd.
Ground Floor & Upper Basement,
Unit No. 1A & 2A, Raheja Tipco Plaza,
Rani Sati Marg, Malad (East),Mumbai- 400097
Maharashtra.

Email us at:
lifeline@iciciprulife.com

Customer Service Helpline
1860 266 7766

ICICI Prudential Life Insurance Co. Ltd. Registered Address: ICICI Pru Life Towers, 1089, Appasaheb Marathe Marg, Prabhadevi, Mumbai-400025.
Reg No:105. Insurance is the subject matter of the solicitation.
Unique Identification Number as specified by IRDAI 105N151V08

Policy Schedule ICICI Pru iProtect Smart (UIN: 105N151V08)
(This is a Non-Linked Non-Par Life Individual pure risk premium product)

Policy Preamble

This Policy is the evidence of a contract between ICICI Prudential Life Insurance Company Limited (Us/We/Company) and the Policyholder (You) referred to below.

We have issued this Policy on the basis of the details provided by You in the Proposal Form submitted along with the required declarations, personal statement, applicable medical reports, the first premium deposit and any other information and documentation which constitute evidence of the insurability of the Life Assured for the issuance of the Policy.

We agree to provide the benefits set out in this Policy subject to its terms and conditions.

Policy Schedule

Name of the Life Assured:

Address:	Category: Medical/Non-Medical		
Date of Birth:	Age (Years):	Gender: M/F/T	Age Admitted: Y/N

Name of the Policyholder:

Policy No:	Benefit Option:

Policy Issue Date:	Date of Maturity:
Policy Acceptance Date:	Policy Term in years:

Premium Payment Term in years:	Periodicity of payment of premium (premium frequency):
Premium payment option:	Accelerated Critical Illness Benefit Term in years:
Total instalment premium (Rs.):	Accelerated Critical Illness Benefit (Rs.):
Sum Assured (Rs.):	Policy sourced by Distance Mode: Y/N
Accidental Death Benefit (Rs.):	Accidental Death Benefit Term in years:

Death Benefit Payout Option:	Due date of last premium payable:

Option	Sum Assured payable
Lump sum	
Income	
Increasing Income	

Nominee(s) Name	Gender	Nominee's Age	Percentage Share	Relationship to the Life Assured	Appointee Name [in case the Nominee is a minor]	Appointee's Gender	Appointee's Age	Relationship of the appointee with the Life Assured

Goods and Services Tax and/or cesses would be charged extra, as applicable.

Policy Schedule, terms and conditions of the Policy and the endorsements by Us, if any, shall form an integral part of this contract and shall be binding on Us and You.

The Policy shall stand cancelled by Us, without any further notice, in the event of dishonour of the first premium deposit.

Please immediately inform Us about any change in address or contact details.

Signed for and on behalf of the ICICI Prudential Life Insurance Company Limited, at Head Office, Mumbai on ……. (Issue Date)

<<<Authorised Signatory >>>

<<<Designation>>>

Version ……

Stamp duty of Rs. …….. (Rupees …….Only) paid by Pay order, vide receipt no. …… dated ……...

This is an output of a digitally signed print file

Please examine the policy and approach Us immediately in case of any discrepancies.

PART B

Definitions

1. Age means age at last birthday.
2. Accident means a sudden, unforeseen and involuntary event caused by external, visible and violent means.
3. Annualized Premium means the premium amount payable in a year chosen by the policyholder, excluding the taxes, rider premiums, underwriting extra premiums and loadings for modal premiums, if any.
4. Appointee means the person appointed by You to receive the benefits payable under the Policy till Your Nominee is a minor.
5. Death Benefit means the benefit, which is payable on death or diagnosis of Terminal Illness as specified in the Policy Document.
6. Death Benefit Payout Option is the manner in which the Nominee receives the Death Benefit payable under the Policy.
7. Claimant means the person entitled to receive the Policy benefits and includes You, the nominee, the assignee, the legal heir, the legal representative(s) or the holder(s) of succession certificate as the case may be.
8. Date of commencement of risk is later of Policy Issue Date or Policy Acceptance Date
9. Date of Maturity means the date specified in the Policy Schedule on which the term of the Policy ends.
10. Distance Mode means every activity of solicitation (including lead generation) and sale of insurance products through the following modes: (i) voice mode, which includes telephone-calling (ii) short messaging service (SMS) (iii) electronic mode which includes e-mail, internet and interactive television (DTH) (iv) physical mode which includes direct postal mail and newspaper and magazine inserts and (v) solicitation through any means of communication other than in person.
11. Insured event is the event on the happening of which, benefits under Your policy become payable.
12. Life Assured means the person named in the Policy Schedule on whose life the Policy has been issued.
13. Limited Pay means premiums need to be paid regularly for a limited portion of the Policy Term.
14. Medical Practitioner is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of licence The Medical Practitioner should neither be the insured person(s) himself nor related to the insured person(s) by blood or marriage.
15. Nominee means the person named in the Policy Schedule who has been nominated by You to receive benefits in respect of this Policy.
16. Policy means the contract of Insurance entered into between You and Us as evidenced by the “Policy document”.
17. Policy Acceptance Date means the date as specified in the Policy Schedule, from which the policy was effected.
18. Policy document means this document, the Proposal Form, the Policy Schedule and any additional information/document(s) provided to Us in respect of the Proposal Form, and any endorsement issued by Us.
19. Policy Issue Date means the date as specified in the Policy Schedule.
20. Policyholder or the Proposer or You or Your means the owner of the Policy at any point of time.
21. Policy Term means the period between the Policy Acceptance Date and the Date of Maturity specified in the Policy Schedule.
22. Policy Schedule means the policy schedule and any endorsements attached to and forming part of this Policy.
23. Premium means the instalment premium in case of Regular Pay and Limited Pay or single premium in case of Single Pay specified in the Policy Schedule which is payable/has been received under the Policy.

24. Premium Payment Term means the period specified in the Policy Schedule during which Premium is payable.
25. Proposal Form means a form to be completed by You for availing an insurance policy, and to furnish all Material information required by Us to assess risk and to decline or to undertake the risk, and in the event of acceptance of risk, to determine the rates, advantages, terms and conditions of a cover to be granted.
    Explanation: "Material" shall mean and include all important, essential and relevant information that enables Us to take an informed decision while underwriting the risk.
26. Regulator means the authority that has regulatory jurisdiction and powers over Us. Currently the Regulator is the Insurance Regulatory and Development Authority of India (IRDAI).
27. Regular Pay means premiums need to be paid regularly throughout the Policy term.
28. Revival of the Policy means restoration of Policy benefits.
29. Revival period means the period of five consecutive years from the due date of the first unpaid premium and before the termination date of the Policy, during which period You are entitled to revive the policy.
30. Single Pay means premium needs to be paid once at the start of the Policy.
31. Sum Assured means the amount specified in the Policy Schedule.
32. Surrender means complete withdrawal/termination of the Policy by You.
33. Total Premiums Paid means the total of all premiums received, excluding any extra premium, any rider premium and taxes.
34. Unexpired risk premium value means an amount, if any, that becomes payable in case of surrender or discontinuance of premium in single/ limited pay policies in accordance with the terms and conditions of the Policy.
35. You or Your means the Policyholder of the Policy at any point of time.
36. We or Us or Our or Company means ICICI Prudential Life Insurance Company Limited.

PART C

1. Benefits available under the policy:

1.1 Death Benefit

We shall pay the Death Benefit as per the Death Benefit Payout Option stated on Your Policy Schedule upon diagnosis of Terminal Illness or death of the Life Assured whichever is earlier provided the Policy is in force as on the date of diagnosis of Terminal Illness or the date of death of the Life Assured. A Life Assured shall be regarded as "Terminally Ill" only if that Life Assured is diagnosed as suffering from a condition which, in the opinion of two independent Medical Practitioners, specializing in treatment of such illness, is highly likely to lead to death within 6 months. The terminal illness must be diagnosed and confirmed by Medical Practitioners registered with Indian Medical Association and approved by Us. We reserve the right for independent assessment of the Terminal Illness. Death Benefit would be as per the below table:

Premium Payment Option	Death Benefit
Single Pay	Higher of 125% of the single premium or the sum assured as stated on your policy schedule to be paid on death.
Regular Pay and Limited Pay	Higher of 7 times the annualized premium or 105% of the total premiums received up to the date of death or the sum assured as stated on your policy schedule to be paid on death.

a. The Policy shall terminate on payment of the benefit and all rights, benefits and interests under the Policy shall stand extinguished.
b. The benefit amount may be taxable as per the prevailing tax laws.

1.2 Waiver of Premium on Permanent Disability due to accident

a. Upon the diagnosis of Permanent Disability (as defined below) of the Life Insured which arises due to an Accident, We shall waive all future premiums payable for all benefits under the Policy during the remaining Premium Payment Term of the Policy provided the Policy is in force as on the date of diagnosis of Permanent Disability of the Life Assured.

b. The Policy will continue for the Death Benefit and Accidental Death Benefit.

For the purpose of this benefit, "Permanent Disability" means the inability of the Life Assured to perform at least 3 of the following 6 activities of daily work:

- Mobility: The ability to walk a distance of 200 meters on flat ground.
- Bending: The ability to bend or kneel to touch the floor and straighten up again and the ability to get into a standard saloon car, and out again.
- Climbing: The ability to climb up a flight of 12 stairs and down again, using the handrail if needed.
- Lifting: The ability to pick up an object weighing 2kg at table height and hold for 60 seconds before replacing the object on the table.
- Writing: The manual dexterity to write legibly using a pen or pencil, or type using a desktop personal computer keyboard.

- Blindness: The permanent and irreversible loss of sight to the extent that even when tested with the use of visual aids, vision is measured at 3/60 or worse in the better eye using a Snellen eye chart.

Provided that the disability should have lasted for at least 180 days without interruption from the date of disability and must be deemed permanent by a Company empanelled Medical Practitioner. In the event of death of the insured within the above period, the policy shall terminate on payment of applicable benefits and all rights, benefits and interests under the policy shall stand extinguished.

1.3 Accidental Death Benefit

a. In the event of the Life Assured's death due to an Accident, where both Accident and death occur during the Accidental Death Benefit Term, the Accidental Death Benefit as mentioned on the Policy Schedule will be payable by Us forthwith as a lump sum subject to the terms and conditions below. This is an additional benefit and will be paid in addition to the Death Benefit.
b. The Accident shall result in bodily injury or injuries to the Life Assured independently of any other means. Such injury or injuries shall, within 180 days of the occurrence of the Accident, directly and independently of any other means cause the death of the Life Assured before the expiry of the Accidental Death Benefit cover. In the event of the death of the Life Assured after 180 days of the occurrence of the Accident, the Company shall not be liable to pay the Accidental Death Benefit. The benefit will be payable if the accident occurs within the Accidental Death Benefit Term even if the death occurs beyond the Accidental Death Benefit Term (however within 180 days of the accident).
c. The Policy must be in full force at the time of Accident.
d. The Company shall not be liable to pay this benefit in case the accident and subsequent death of the Life Assured occurs after the accidental death benefit term.
e. Accidental Death Benefit cannot be changed during the Policy Term.
f. Upon payment of the Accidental Death Benefit, the Policy will terminate and all rights, benefits and interests under the Policy will stand extinguished
g. In case no AD Benefit is triggered within the AD Benefit term, then AD Benefit will terminate and premiums corresponding to it will not be payable. However You would be required to pay premiums for all other Benefits to keep the policy in force.

1.4 Life Stage Protection

You can choose to increase the Death Benefit at the key milestones of marriage and child birth/ adoption of child, provided no claim has been admitted for any benefits under the policy and the policy is in force.
The Death Benefit can be increased without any medicals on any one or all of the below events during the term of the Policy. This feature is available to a Life Assured underwritten as a standard life at the time of inception of the Policy per the Board Approved Underwriting Policy.

Event	Additional Death Benefit (percentage of original Sum Assured)	Subject to maximum additional Death Benefit
Marriage	50%	Rs. 50,00,000

Birth / Legal adoption of 1st child	25%	Rs. 25,00,000
Birth / Legal adoption of 2nd child	25%	Rs. 25,00,000

On exercising the option, You will have to pay an additional premium for the additional Sum Assured for the outstanding term of the policy based on your then age. Hence the future premium payable by You on exercising this option will be the sum of original premium and additional premium.

No fee is chargeable for this option.

This feature is available only with Regular premium payment option. Such increase in sum assured is only applicable to base death benefit. The AD Benefit will remain unchanged.
Premium will be recalculated based on the increased Death Sum Assured and outstanding policy term. This is subject to:

1. Minimum policy term (which is 5 years) available at the time of the exercising this feature.
2. The Life Assured being less than 50 years of age at the time of the event.

Such increase needs to be exercised within 6 months of the event and will be effective from the next policy anniversary. The additional premium will also be payable from next policy anniversary.

1.5 Death Benefit Payout Options:

The Death Benefit will be payable as per one of the below options chosen by You at the inception of Your policy and mentioned in Your Policy Schedule.

1. Lump Sum Option – Entire Death Benefit amount is payable as lump sum.
2. Income Option – 10% of the Death Benefit amount is payable every year for 10 years. This will be payable in equal monthly instalments in advance at the rate of 0.83333% of Death Benefit amount.
   The beneficiary can also advance the first year's income as a lump sum. The monthly income will then continue from the subsequent month for next 9 years advance at the rate of 0.80% of Death Benefit amount.
3. Lump sum and Income – The part of the Death Benefit amount to be paid out as lump sum is chosen at inception. The balance Death Benefit amount will be paid out in equal monthly instalments in advance at the rate of 0.83333% per month over 10 years.
4. Increasing Income Option – Benefit amount is payable in monthly instalments for 10 years starting with 10% of the benefit amount per annum in the first year. The income amount will increase at 10% p.a. simple interest every year thereafter.

For options 2, 3, and 4, You or the nominee as the case may be, will have an option to take the discounted value of the future payouts anytime during the payout term by informing Us of this decision in writing. The present value will be derived using discount rate of 4% p.a..

1.6 Smart Exit Benefit

You have an option to cancel the Policy and receive Smart Exit Benefit, equal to Total Premiums Paid under the Policy. No additional premium is payable to avail this option.

The following conditions are applicable for availing Smart Exit benefit:

- The Sum Assured in the policy at inception is ₹ 6,000,000 or above.
- This option can be exercised in any policy year greater than 25 but not during the last 5 policy years, provided the age of the life assured is 60 years or more at the time of exercise.
- The Policy is in-force with all due premiums paid at the time of exercising this option.
- No claim for any of the underlying benefits has been registered and is under evaluation/ or accepted/ or paid/ being paid on the Policy.

The Policy shall terminate on payment of this benefit (if exercised) and all rights, benefits and interests under this Policy will stand extinguished. You can either opt for Smart Exit Benefit or Unexpired Risk Premium Value as per Clause 3, Part D, i.e. you cannot avail both the benefits simultaneously.

Where Life Stage Protection options has been exercised, Total Premiums Paid includes Premium paid for each tranche of additional sum assured purchased. In case the benefit term for additional benefit(s) (which are benefits other than as mentioned in Part C, Clause 1.1 and 1.2) has expired at the time of exercise of Smart Exit Benefit, then Total Premiums Paid shall exclude the Premium Paid towards such additional benefit(s).

2. Premium payment:

i. You are required to pay Premiums on the due dates and for the amount mentioned in the Policy Schedule.

ii. The grace period for payment of premium is 15 days for monthly frequency of premium payment and 30 days for other frequencies of premium payment. In case of occurrence of the covered events during the grace period, We will pay the benefits as per the terms and conditions of the Policy.

iii. If any premium instalment is not paid within the grace period then the Policy shall lapse and all cover under the Policy will cease.

iv. You are required to pay Premiums for the entire Premium Payment Term.

v. If Single Pay option has been chosen by You, only one Premium is to be paid and no future Premiums are payable.

vi. We are not under any obligation to remind You about the premium due date, except as required by applicable regulations.

vii. The loading based on premium paying modes are mentioned below:

Premium frequency	Loading as a % of Premium
Yearly	NA
Half-yearly	1.25%
Monthly	2.50%

viii. You may pay Premium through any of the following modes:

a) Cash
b) Cheque
c) Demand Draft
d) Pay Order
e) Banker's cheque
f) Internet facility as approved by the Company from time to time
g) Electronic Clearing System / Direct Debit
h) Credit or Debit cards held in your name

ix. Amount and modalities will be subject to our rules and relevant legislation or regulation
x. Any payment made towards first or renewal premium is deemed to be received by Us only when it is received at any of Our branch offices or authorized collection points and after an official printed receipt is issued by Us.
xi. No person or individual or entity is authorized to collect cash or self-cheque or bearer cheque on Our behalf.
xii. Cheque or demand drafts must be drawn only in favour of ICICI Prudential Life Insurance Company Limited.
xiii. Please ensure that You mention the application number for the first premium deposit and the policy number for the renewal premiums on the cheque or demand draft.
xiv. Where Premiums have been remitted otherwise than in cash, the application of the Premiums received will be conditional on the realization of the proceeds of the instrument of payment, including electronic mode.
xv. If You suspend payment of premium for any reason whatsoever, We will not be held liable. In such an event, benefits, if any, will be available only in accordance with the Policy terms and conditions.
xvi. Premiums need to be paid only for the chosen premium payment term. Once premiums have been paid for the premium payment term, the policy benefits will continue for the term of the policy.

3. Maturity / Survival Benefit:

No benefit will be payable upon the maturity of the Policy. At the end of the Policy Term, the Policy will automatically terminate and all rights, benefits and interests under the Policy will stand extinguished.

5. Grace Period

If you are unable to pay an instalment premium by the due date, you will be given a grace period of 15 days for payment of due instalment premium if You have chosen monthly frequency, and 30 days for payment of due instalment premium if You have chosen any other frequency, commencing from the premium due date. The life cover continues during the grace period. In case of death of Life Assured during the grace period, We will pay the applicable Death Benefit.

PART D

1. Free look Period (15 / 30 days refund policy)

You have an option to review the Policy following receipt of the Policy Document. If you are not satisfied with the terms and conditions of this Policy, please return the Policy Document to Us for cancellation with reasons within

i. 15 days from the date you received it, if your Policy is not purchased through Distance Mode
ii. 30 days from the date you received it, if your Policy is an electronic policy or is purchased through Distance Mode

On cancellation of the Policy during the freelook period, We will return the premium paid subject to the following deductions:

i. Proportionate risk premium for the period of cover
ii. Stamp duty under the Policy
iii. Expenses borne by the Company on medical examination, if any

The Policy shall terminate on payment of this amount and all rights, benefits and interests under this Policy will stand extinguished.

2. Paid-up Value

There is no paid-up value under this Policy.

3. Unexpired risk premium value

A. Single Pay:

i. Surrender means voluntary termination of the Policy by you.
ii. The Policy will terminate on surrender and all the rights / title and interest under the Policy shall stand extinguished.
iii. Unexpired risk premium value may be taxable as per the prevailing tax laws.
iv. The bases for computing Unexpired risk premium value factors will be reviewed from time to time and the factors applicable to existing business may be revised subject to the prior approval of the IRDAI.
v. Unexpired risk premium value will be calculated as given below.

Unexpired risk premium value = (Unexpired risk premium value Factor/ 100) * Single Premium

Unexpired risk premium value factors are given in Annexure I

B. Limited Pay:

i. Unexpired risk premium value, if any, will be payable if the policy holder voluntarily terminates the policy during the policy term

Or for lapsed policies on earlier of:

- Death of the Life Assured within the revival period, or
- At the end of the revival period.

Unexpired risk premium value = (Unexpired risk premium value Factor/100) X Annual Premium
Unexpired risk premium value Factors are given in Annexure I

ii. The Policy will terminate on payment of this amount and all the rights / title and interest under the Policy shall stand extinguished.
iii. Unexpired risk premium value may be taxable as per the prevailing tax laws.

C. Regular Pay:

No unexpired risk premium value is payable for Regular Pay policies.

4. Exclusions

4.1. For Waiver of Premium on Permanent Disability the following exclusions shall apply:

i. We will not be liable to provide the Waiver of Premium on Permanent Disability benefit if the Permanent Disability is directly or indirectly due to or caused, occasioned, accelerated or aggravated by, any one of the following:

- Attempted suicide or self-inflicted injuries while sane or insane, or whilst the Life Assured is under the influence of any narcotic substance or drug or intoxicating liquor except under the direction of a medical practitioner; or
- Engaging in aerial flights (including parachuting and skydiving) other than as a fare paying passenger or crew on a licensed passenger-carrying commercial aircraft operating on a regular scheduled route; or
- The Life Assured with criminal intent committing any breach of law; or
- Due to war, whether declared or not or civil commotion; or
- Engaging in hazardous sports / pastimes, i.e. taking part in (or practising for) boxing, caving, climbing, horse racing, jet skiing, martial arts, mountaineering, off piste skiing, pot holing, power boat racing, underwater diving, yacht racing or any race, trial or timed motor sport.
- PD due to accident must be caused by violent, external and visible means.

i. The accident shall result in bodily injury or injuries to the Life Assured independently of any other means. Such injury or injuries shall, within 180 days of the occurrence of the accident, directly and independently of any other means cause the PD of the Life Assured. In the event of PD of the Life Assured after 180 days of the occurrence of the accident, the Company shall not be liable to pay this benefit.

ii. The Company shall not be liable to pay this benefit in case PD of the Life Assured occurs after the date of termination of the policy.

4.2 For Accidental Death Benefit the following exclusions apply:

We will not be liable to pay the Accidental Death Benefit if the Accident is directly or indirectly due to or caused, occasioned, accelerated or aggravated by, any one of the following:

a) Attempted suicide or self-inflicted injuries while sane or insane, or whilst the Life Assured is under the influence of any narcotic substance or drug or intoxicating liquor except under the direction of medical practitioner; or

b) Engaging in aerial flights (including parachuting and skydiving) other than as a fare paying passenger or crew on a licensed passenger-carrying commercial aircraft operating on a regular scheduled route; or

c) The Life Assured with criminal intent, committing any breach of law; or

d) Due to war, whether declared or not or civil commotion; or

e) Engaging in hazardous sports or pastimes, e.g. taking part in (or practising for) boxing, caving, climbing, horse racing, jet skiing, martial arts, mountaineering, off piste skiing, pot holing, power boat racing, underwater diving, yacht racing or any race, trial or timed motor sport.

5. Loan

We will not provide loans under this Policy.

6. Riders

Riders may be offered but only subject to prior approval of the Regulator.

7. Revival

A Policy which has lapsed for non-payment of premium within the grace period may be revived subject to underwriting and the following conditions:

a) The application for revival is made within 5 years from the due date of the first unpaid premium and before the termination date of the Policy. Revival will be based on the prevailing Board approved underwriting policy.
b) You furnish, at your own expense, satisfactory evidence of health as required by Us.
c) The arrears of Premiums together with interest at such rate as We may charge for late payment of premiums are paid. The interest rate applicable in July 2023 is 8.59% p.a. compounded half yearly.
d) The revival of the Policy may be on terms different from those applicable to the Policy before it lapsed for example, extra mortality premiums or charges may be applicable subject to our Board approved underwriting policy.
e) We reserve the right to not revive the Policy. In that case, only the premiums paid towards the revival of the Policy shall be refunded without any interest.
f) The revival will take effect only if it is specifically communicated by Us to You.

8. To whom benefits are payable

Benefits are payable to the Policyholder or to the assignee(s) where an endorsement has been recorded in accordance with Section 38 of the Insurance Act, 1938, and as amended from time to time. In case of death of the Policyholder or assignee(s) as mentioned above, benefits are payable either to the Nominee(s) where a valid nomination has been registered by the Company (in accordance with section 39 of the Insurance Act, 1938, and as amended from time to time), or to the executors, administrators or other legal representatives who obtain representation to the estate of the Policyholder or to such person or persons as directed by a court of competent jurisdiction in India, limited at all times to the monies payable under this Policy.

If the Policyholder and Life Assured are different, then upon death of the Policyholder and subsequent intimation of the death with the Company, the policy shall vest on the Life Assured. Thereafter, the Life Assured shall become the Policyholder and will be entitled to all benefits and subject to all liabilities as per the terms and conditions of the policy. The Life Assured cum Policyholder can register due nomination as per Section 39 of the Insurance Act, 1938 as amended from time to time.

We hereby agree to pay the appropriate benefits under the Policy subject to:

a) Our satisfaction of the benefits having become payable on the happening of an event as per the Policy terms and conditions,

b) The title of the said person or persons claiming payment.

PART E: Not Applicable

PART F

General Conditions

1. Age

We have calculated the premiums under the Policy on the basis of the Age of the Life Assured as declared by You in the Proposal Form. In case if the age proof of the Life Assured was not submitted at the time of Proposal, You will be required to submit such an Age proof of the Life Assured acceptable to Us, and have the Age admitted.

If the Age of the life assured has been misstated, We will take one of the following actions:

a) If the Correct Age of the Life Assured makes him ineligible for this product, We will offer a suitable plan as per Our underwriting norms. If You do not wish to opt for the alternative plan or if it is not possible for Us to grant any other plan, We will cancel the Policy and refund the premiums paid (without interest) under the Policy after adjustment against the paid benefits. The Policy will terminate on the said payment.

b) If the Correct Age of the Life Assured makes him eligible for this Policy, revised Premium depending upon the Correct Age will be payable. Difference of premium from inception will be collected with interest, if age declared is higher and excess premium collected will be refunded without interest, if age is found to be lower.

The provisions of Section 45 of the Insurance Act, 1938, as amended from time to time shall be applicable.

2. Nomination

Nomination under the Policy will be governed by Section 39 of the Insurance Act, 1938, as amended from time to time. Please refer to Annexure II for details on this section.

3. Assignment

Assignment of the Policy will be governed by Section 38 of the Insurance Act, 1938, as amended from time to time. Please refer to Annexure III for details on this section.

4. Incontestability

Incontestability will be as per Section 45 of the Insurance Act, 1938, as amended from time to time. Please refer to Annexure IV for details on this section.

5. Misstatement & Fraud

Misstatement and Fraud will be as per Section 45 of the Insurance Act, 1938, as amended from time to time. Please refer to Annexure IV for details on this section.

The Policy is subject to the terms and conditions as mentioned in the Policy document and is governed by the Laws of India.

6. Communication address

Our communication address is:

Address: Customer Service Desk
ICICI Prudential Life Insurance Company Limited,
Ground Floor & Upper Basement,
Unit No. 1A & 2A, RahejaTipco Plaza,
Rani Sati Marg, Malad (East),
Mumbai- 400097
Maharashtra.

Telephone: 1860 266 7766
Facsimile: 022 4205 8222
E-mail: lifeline@iciciprulife.com

We expect You to immediately inform Us about any change in Your address or contact details.

7. Electronic transactions

All transactions carried out by You through Internet, electronic, call centres, tele-service operations, computer, automated machines network or through other means of communication will be valid and legally binding on Us as well as You.

This will be subject to the relevant guidelines and terms and conditions as may be specified by Us.

8. Jurisdiction

The Policy is subject to the terms and conditions as mentioned in the Policy document and is governed by the laws of India.

Indian courts shall have exclusive jurisdiction over all differences or disputes arising in relation to this Policy.

9. Legislative changes

All benefits payable under the Policy are subject to the tax laws and other financial enactments as they exist from time to time.

The Policy terms and conditions may be altered based on any future legislative or regulatory changes.

10. Payment of claim

For processing a death claim under this Policy, We will require the following documents (as may be relevant):

For natural deaths:

a) Claimant's Statement
b) Original Policy Document
c) Death Certificate of the Life Assured issued by the local municipal authority
d) Cancelled Cheque for processing electronic payment
e) Claimant's Photo Identity proof and address proof
f) Medical cause of the death certificate issued by the last treating/ last attending doctor, if any
g) Medical records (Admission notes, Discharge Summary/Death summary, test reports etc., if any
h) Any other documents or information as may be required by the Company for processing of the claim depending on the cause of the death.

For unnatural deaths:

a) Claimant's Statement
b) Original Policy Document
c) Death Certificate of the Life Assured issued by the local municipal authority
d) Cancelled Cheque for processing electronic payment
e) Claimant's Photo Identity proof & address proof
f) Post Mortem report & viscera/ chemical analysis report
g) FIR report, final police investigation report, police panchnama/ Inquest report, driving license
h) Any other documents or information as may be required by the Company for processing of the claim depending on the cause of the death.

Claim payments are made only in Indian currency in accordance with the prevailing Exchange control regulations and other relevant laws and regulations in India. In case the Claimant is unable to provide any or all of the above documents, in exceptional circumstances such as a natural calamity, the Company may at its own discretion conduct an investigation and may subsequently settle the claim.

11. Suicide

If the Life Assured, whether sane or insane, commits suicide within 12 months from the date of commencement of risk of this Policy, We will refund higher of 80% of the total premiums paid, if any till the date of death or unexpired risk premium value as available on date of death, provided the policy is in force.

In the case of a revived Policy, if the Life Assured, whether sane or insane, commits suicide within 12 months of the date of revival of the Policy, higher of 80% of the total premiums paid, if any till date of death or unexpired risk premium value as available on date of death will be payable by Us.

The Policy will terminate on making such a payment and all rights, benefits and interests under the Policy will stand extinguished.

12. Issue of duplicate policy

We shall issue a duplicate of Policy document, on receipt of a written request for the same from You along with the necessary documents as may be required by Us and at such charges as may be applicable from time to time. The current charges for issuance of duplicate policy is Rs. 200. Freelook option is not available on issue of duplicate Policy document.

13. Amendment to policy document

Any variations, modifications or amendment of any terms of the Policy document shall be communicated to you in writing.

PART G

Grievance Redressal Mechanism & List of Ombudsman

1. Customer service

For any clarification or assistance You may contact Our advisor or call Our customer service representative (between 10.00 a.m. to 7.00 p.m., Monday to Saturday; excluding national holidays) on the numbers mentioned on the reverse of the Policy folder or on Our website: www.iciciprulife.com.

Alternatively, You may communicate with Us at any of our branches or the customer service desk whose details are mentioned in the Welcome Letter.

For updated contact details, We request You to regularly check Our website.

i. Grievance Redressal Officer:

If You do not receive any resolution from Us or if You are not satisfied with Our resolution, You may get in touch with Our designated grievance redressal officer (GRO) at gro@iciciprulife.com or 1860 266 7766.

Address:

ICICI Prudential Life Insurance Company Limited,
Ground Floor & Upper Basement,
Unit No. 1A & 2A, Raheja Tipco Plaza,
Rani Sati Marg, Malad (East),
Mumbai- 400097
Maharashtra.

For more details please refer to the “Grievance Redressal” section on www.iciciprulife.com

ii. Grievance Redressal Committee:

If You do not receive any resolution or if You are not satisfied with the resolution provided by the GRO, You may escalate the matter to Our internal grievance redressal committee at the address mentioned below:

ICICI Prudential Life Insurance Company Limited,
Ground Floor & Upper Basement,
Unit No. 1A & 2A, RahejaTipco Plaza,
Rani Sati Marg, Malad (East),
Mumbai- 400097
Maharashtra.

If you are not satisfied with the response or do not receive a response from us within 15 days, you may approach the Grievance Cell of the Insurance Regulatory and Development Authority of India (IRDAI) on the following contact details:

IRDAI Grievance Call Centre (IGCC) TOLL FREE NO:155255
Email ID: complaints@irda.gov.in

You can also register your complaint online at http://www.igms.irda.gov.in/
Address for communication for complaints by fax/paper:

Consumer Affairs Department
Insurance Regulatory and Development Authority of India
Sy.No.115/1, Financial District, Nanakramguda,
Gachibowli, Hyderabad – 500 032.

2. Insurance Ombudsman:

The Central Government has established an office of the Insurance Ombudsman for redressal of grievances with respect to life insurance policies. As per Insurance Ombudsman Rules, 2017 and Insurance Ombudsman (Amendment) Rules, 2021 the Ombudsman shall receive and consider complaints or alleging deficiency in performance required of an insurer (including its agents and intermediaries) or an insurance broker, on any of the following grounds:

a. delay in settlement of claims, beyond the time specified in the regulations, framed under the Insurance Regulatory and Development Authority of India Act, 1999;
b. any partial or total repudiation of claims, by the life insurer, General insurer or the health insurer;
c. disputes over premium paid or payable in terms of insurance policy;
d. misrepresentation of policy terms and conditions at any time in the policy document or policy contract;
e. legal construction of insurance policies in so far as the dispute relates to claim;
f. policy servicing related grievances against insurers, their agents and intermediaries;
g. issuance of life insurance policy, general insurance policy including health insurance policy which is not in conformity with proposal form submitted by the proposer:
h. non-issuance of insurance policy after receipt of premium ; in life insurance and general insurance including health insurance; and
i. any other matter arising from non-observance of or non-adherence to the provisions of any regulations made by the Authority with regard to protection of policyholders‘ interests

or otherwise, or of any circular, guideline or instruction issued by the Authority, or of the terms and conditions of the policy contract, in so far as such matter relates to issues referred to in clauses (a) to (h).

Manner in which complaint to be made

(1) Any person who has a grievance against an insurer or insurance broker, may himself or through his legal heirs, nominee or assignee, make a complaint in writing to the Insurance Ombudsman within whose territorial jurisdiction the branch or office of the insurer or the insurer broker as the case may be complained against or the residential address or place of residence of the complainant is located.

(2) The complaint shall be in writing, duly signed or made by way of electronic mail or online through the website of the Council for Insurance Ombudsmen by the complainant or through his legal heirs, nominee or assignee and shall state clearly the name and address of the complainant, the name of the branch or office of the insurer against whom the complaint is made, the facts giving rise to the complaint, supported by documents, the nature and extent of the loss caused to the complainant and the relief sought from the Insurance Ombudsman.

(3) No complaint to the Insurance Ombudsman shall lie unless—

(a) the complainant has made a representation in writing or through electronic mail or online through website of the insurer or insurance broker concerned the insurer named in the complaint and—

i. either the insurer or insurance broker, as the case may be had rejected the complaint; or
ii. the complainant had not received any reply within a period of one month after the insurer or insurance broker, as the case may be received his representation; or
iii. the complainant is not satisfied with the reply given to him by the insurer or insurance broker, as the case may be;;

(b) The complaint is made within one year—

(i) after the order of the insurer rejecting the representation is received; or
(ii) after receipt of decision of the insurer or insurance broker, as the case may be which is not to the satisfaction of the complainant;
(iii) after expiry of a period of one month from the date of sending the written representation to the insurer or insurance broker, as the case may be if the insurer or insurance broker, as the case may be named fails to furnish reply to the complainant.

(4) The Ombudsman shall be empowered to condone the delay in such cases as he may consider necessary, after calling for objections of the insurer or insurance broker, as the case may be against the proposed condonation and after recording reasons for condoning the delay and in case the delay is condoned, the date of condonation of delay shall be deemed to be the date of filing of the complaint, for further proceedings under these rules.

(5) No complaint before the Insurance Ombudsman shall be maintainable on the same subject matter on which proceedings are pending before or disposed of by any court or consumer forum or arbitrator.

(6) The Council for Insurance Ombudsmen shall develop a complaints management system, which shall include an online platform developed for the purpose of online submission and tracking of the status of complaints made under rule 14

The Ombudsman shall not award compensation exceeding more than Rupees Thirty Lakhs (including relevant expenses, if any).

We have given below the details of the existing offices of the Insurance Ombudsman. We request You to regularly check our website at www.iciciprulife.com or the website of the IRDAI at www.irdai.gov.in for updated contact details.

Office of the Ombudsman	Address	Contact Details	Areas of Jurisdiction
AHMEDABAD	Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad - 380 001	Tel.:- 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat , Dadra & Nagar Haveli, Daman and Diu
BENGALURU	Office of Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560078	Tel No: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka
BHOPAL	Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003.	Tel.:- 0755-2769201, 2769202 Fax : 0755-2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh & Chhattisgarh
BHUBANESHWAR	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009.	Tel.:- 0674-2596455/2596461, Fax : 0674-2596429 Email: bimalokpal.bhubaneswar@cioins.co.in	Odisha
CHANDIGARH	Office of the Insurance Ombudsman,	Tel.: 0172 - 2706196 / 2706468 Fax: 0172 – 2708274	Punjab, Haryana(excluding Gurugram,

	S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017	Email: bimalokpal.chandigarh@cioins.co.in	Faridabad, Sonepat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.
CHENNAI	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai – 600 018.	Tel.: 044 - 24333668 / 24335284 Fax: 044 – 24333664 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Tamil Nadu Puducherry Town and Karaikal (which are part of Puducherry).
DELHI	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002.	Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
ERNAKULAM	Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015.	Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
GUWAHATI	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor,	Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram,

	Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001 (Assam).		Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004.	Tel.: 040 - 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR	Office of the Insurance Ombudsman,Jeevan Nidhi – II Bldg., Gr. Floor,Bhawani Singh Marg,Jaipur - 302 005.	Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan
KOLKATA	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor,4, C.R. Avenue, Kolkatta - 700 072	Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001.	Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow,

			Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI	Office of the Insurance Ombudsman,3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054.	Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA	Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301.	Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah,

			Farrukhabad, Firozbad, Gautam buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA	Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, North Wing Bailey Road, Patna 800001.	Tel.: 0612-2680952 Email: bimalokpal.patna@cioins.co.in	Bihar,Jharkhand
PUNE	Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030.	Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

Annexure I – Unexpired risk premium value factors

For Single Pay:

Policy Year \ Policy Term	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
1	30	30	30	35	35	40	40	40	40	40	40	40	40	40	40	40
2	25	25	25	35	35	35	35	35	35	35	35	35	35	35	40	40
3	15	20	20	30	30	35	35	35	35	35	35	35	35	35	40	40
4	5	15	15	25	30	30	30	35	35	35	35	35	35	35	40	40
5	0	5	5	20	25	30	30	30	30	35	35	35	35	35	40	40
6	0	0	5	15	20	25	25	30	30	35	35	35	35	35	40	40
7	0	0	0	5	15	20	20	25	30	30	35	35	35	35	40	40
8	0	0	0	0	5	15	15	20	25	30	30	35	35	35	40	40
9	0	0	0	0	0	5	10	15	20	25	30	30	35	35	40	40
10	0	0	0	0	0	0	5	10	15	20	25	25	30	35	35	35
11	0	0	0	0	0	0	0	5	10	15	25	25	30	30	35	35
12	0	0	0	0	0	0	0	0	5	10	15	20	25	30	35	35
13	0	0	0	0	0	0	0	0	0	5	10	15	20	25	30	35
14	0	0	0	0	0	0	0	0	0	0	5	5	15	20	25	30
15	0	0	0	0	0	0	0	0	0	0	0	5	10	15	20	25
16	0	0	0	0	0	0	0	0	0	0	0	0	5	10	20	20
17	0	0	0	0	0	0	0	0	0	0	0	0	0	5	10	15
18	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	10
19	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
20	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

For Limited pay:

As per Annexure VIII of the File and Use

Annexure II – Section 39 – Nomination by policyholder

Nomination of a life insurance Policy is as below in accordance with Section 39 of the Insurance Act, 1938, as amended from time to time. The extant provisions in this regard are as follows:

1. The policyholder of a life insurance on his own life may nominate a person or persons to whom money secured by the policy shall be paid in the event of his death.

2. Where the nominee is a minor, the policyholder may appoint any person to receive the money secured by the policy in the event of policyholder's death during the minority of the nominee. The manner of appointment to be laid down by the insurer.

3. Nomination can be made at any time before the maturity of the policy.

4. Nomination may be incorporated in the text of the policy itself or may be endorsed on the policy communicated to the insurer and can be registered by the insurer in the records relating to the policy.

5. Nomination can be cancelled or changed at any time before policy matures, by an endorsement or a further endorsement or a will as the case may be.

6. A notice in writing of Change or Cancellation of nomination must be delivered to the insurer for the insurer to be liable to such nominee. Otherwise, insurer will not be liable if a bonafide payment is made to the person named in the text of the policy or in the registered records of the insurer.

7. Fee to be paid to the insurer for registering change or cancellation of a nomination can be specified by the Authority through Regulations.

8. On receipt of notice with fee, the insurer should grant a written acknowledgement to the policyholder of having registered a nomination or cancellation or change thereof.

9. A transfer or assignment made in accordance with Section 38 shall automatically cancel the nomination except in case of assignment to the insurer or other transferee or assignee for purpose of loan or against security or its reassignment after repayment. In such case, the nomination will not get cancelled to the extent of insurer's or transferee's or assignee's interest in the policy. The nomination will get revived on repayment of the loan.

10. The right of any creditor to be paid out of the proceeds of any policy of life insurance shall not be affected by the nomination.

11. In case of nomination by policyholder whose life is insured, if the nominees die before the policyholder, the proceeds are payable to policyholder or his heirs or legal representatives or holder of succession certificate.

12. In case nominee(s) survive the person whose life is insured, the amount secured by the policy shall be paid to such survivor(s).
13. Where the policyholder whose life is insured nominates his
    a. parents or
    b. spouse or
    c. children or
    d. spouse and children
    e. or any of them

    the nominees are beneficially entitled to the amount payable by the insurer to the policyholder unless it is proved that policyholder could not have conferred such beneficial title on the nominee having regard to the nature of his title.

14. If nominee(s) die after the policyholder but before his share of the amount secured under the policy is paid, the share of the expired nominee(s) shall be payable to the heirs or legal representative of the nominee or holder of succession certificate of such nominee(s).

15. If policyholder dies after maturity but the proceeds and benefit of the policy has not been paid to him because of his death, his nominee(s) shall be entitled to the proceeds and benefit of the policy.

16. The provisions of Section 39 are not applicable to any life insurance policy to which Section 6 of Married Women's Property Act, 1874 applies or has at any time applied. Where nomination is intended to be made to spouse or children or spouse and children under Section 6 of MWP Act, it should be specifically mentioned on the policy. In such a case only, the provisions of Section 39 will not apply.

    Disclaimer: This is a simplified version of Section 39 of the Insurance Act, 1938, as amended from time to time. The policyholders are advised to refer to The Insurance Act, 1938, as amended from time to time for complete and accurate details.

Annexure III – Section 38 – Assignment and Transfer of Insurance Policies

Assignment or transfer of a policy should be in accordance with Section 38 of the Insurance Act, 1938, as amended from time to time. The extant provisions in this regard are as follows:

1. This policy may be transferred/assigned, wholly or in part, with or without consideration.

2. An Assignment may be effected in a policy by an endorsement upon the policy itself or by a separate instrument under notice to the Insurer.

3. The instrument of assignment should indicate the fact of transfer or assignment and the reasons for the assignment or transfer, antecedents of the assignee and terms on which assignment is made.

4. The assignment must be signed by the transferor or assignor or duly authorized agent and attested by at least one witness.

5. The transfer of assignment shall not be operative as against an insurer until a notice in writing of the transfer or assignment and either the said endorsement or instrument itself or copy there of certified to be correct by both transferor and transferee or their duly authorised agents have been delivered to the insurer.

6. Fee to be paid for assignment or transfer can be specified by the Authority through Regulations.

7. On receipt of notice with fee, the insurer should Grant a written acknowledgement of receipt of notice. Such notice shall be conclusive evidence against the insurer of duly receiving the notice.

8. If the insurer maintains one or more places of business, such notices shall be delivered only at the place where the policy is being serviced.

9. The insurer may accept or decline to act upon any transfer or assignment or endorsement, if it has sufficient reasons to believe that it is
    a. not bonafide or
    b. not in the interest of the policyholder or
    c. not in public interest or
    d. is for the purpose of trading of the insurance policy.

10. Before refusing to act upon endorsement, the Insurer should record the reasons in writing and communicate the same in writing to Policyholder within 30 days from the date of policyholder giving a notice of transfer or assignment.

11. In case of refusal to act upon the endorsement by the Insurer, any person aggrieved by the refusal may prefer a claim to IRDAI within 30 days of receipt of the refusal letter from the Insurer.

12. The priority of claims of persons interested in an insurance policy would depend on the date on which the notices of assignment or transfer is delivered to the insurer; where there are more than one instruments of transfer or assignment, the priority will depend on dates of delivery of such notices. Any dispute in this regard as to priority should be referred to Authority.

13. Every assignment or transfer shall be deemed to be absolute assignment or transfer and the assignee or transferee shall be deemed to be absolute assignee or transferee, except
    a. where assignment or transfer is subject to terms and conditions of transfer or assignment OR
    b. where the transfer or assignment is made upon condition that
        i. the proceeds under the policy shall become payable to policyholder or nominee(s) in the event of assignee or transferee dying before the insured OR
        ii. the insured surviving the term of the policy

    Such conditional assignee will not be entitled to obtain a loan on policy or surrender the policy. This provision will prevail notwithstanding any law or custom having force of law which is contrary to the above position.

14. In other cases, the insurer shall, subject to terms and conditions of assignment, recognize the transferee or assignee named in the notice as the absolute transferee or assignee and such person
    a. shall be subject to all liabilities and equities to which the transferor or assignor was subject to at the date of transfer or assignment and
    b. may institute any proceedings in relation to the policy
    c. obtain loan under the policy or
    d. the policy without obtaining the consent of the transferor or assignor or making him a party to the proceedings

    Disclaimer: This is a simplified version of Section 38 of the Insurance ~~Laws~~ Act, 1938, as amended from time to time. The policyholders are advised to refer to The Insurance Act, 1938, as amended from time to time for complete and accurate details.

Annexure IV – Section 45 – Policy shall not be called in question on the ground of mis-statement after three years

Provisions regarding policy not being called into question in terms of Section 45 of the Insurance Act, 1938, as amended from time to time are as follows:

1. No Policy of Life Insurance shall be called in question on any ground whatsoever after expiry of 3 yrs from
    a) the date of issuance of policy or
    b) the date of commencement of risk or
    c) the date of revival of policy or

d) the date of rider to the policy

whichever is later.

2. On the ground of fraud, a policy of Life Insurance may be called in question within 3 years from
    a) the date of issuance of policy or
    b) the date of commencement of risk or
    c) the date of revival of policy or
    d) the date of rider to the policy

    whichever is later.

    For this, the insurer should communicate in writing to the insured or legal representative or nominee or assignees of insured, as applicable, mentioning the ground and materials on which such decision is based.

3. Fraud means any of the following acts committed by insured or by his agent, with the intent to deceive the insurer or to induce the insurer to issue a life insurance policy:
    a) The suggestion, as a fact of that which is not true and which the insured does not believe to be true;
    b) The active concealment of a fact by the insured having knowledge or belief of the fact;
    c) Any other act fitted to deceive; and
    d) Any such act or omission as the law specifically declares to be fraudulent.

4. Mere silence is not fraud unless, depending on circumstances of the case, it is the duty of the insured or his agent keeping silence to speak or silence is in itself equivalent to speak.

5. No Insurer shall repudiate a life insurance Policy on the ground of Fraud, if the Insured / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the policyholder, if alive, or beneficiaries

6. Life insurance Policy can be called in question within 3 years on the ground that any statement of or suppression of a fact material to expectancy of life of the insured was incorrectly made in the proposal or other document basis which policy was issued or revived or rider issued. For this, the insurer should communicate in writing to the insured or legal representative or nominee or assignees of insured, as applicable, mentioning the ground and materials on which decision to repudiate the policy of life insurance is based.

7. In case repudiation is on ground of mis-statement and not on fraud, the premium collected on policy till the date of repudiation shall be paid to the insured or legal representative or nominee or assignees of insured, within a period of 90 days from the date of repudiation.

8. Fact shall not be considered material unless it has a direct bearing on the risk undertaken by the insurer. The onus is on insurer to show that if the insurer had been aware of the said fact, no life insurance policy would have been issued to the insured.

9. The insurer can call for proof of age at any time if he is entitled to do so and no policy shall be deemed to be called in question merely because the terms of the policy are adjusted on subsequent proof of age of life insured. So, this Section will not be applicable for questioning age or adjustment based on proof of age submitted subsequently.

ishield_ICICI_Pru_iProtect_Smart_Annexure_V_Policy Document_Option_All-in-One

A Non-Linked Non-Par Life Individual pure risk premium product

Dear <Customer Name>,
This is your life insurance policy. It is a legal
Document. Please read it carefully.
We have highlighted some important points regarding your policy that you should keep in mind:

1. **YOUR POLICY DETAILS**
Name of your plan : <<Product Name>>
Policy Number : <Policy Number>
Mobile Number : <Mobile Number>
Email ID : <Email ID>
Person insured in this policy: <Name of Life Assured>
Sum Assured (Insurance Cover Amount) (in ‘) : <Amount>
Accidental Death Benefit (Accidental Death Cover) (in ‘): <Amount>
Accelerated Critical Illness Benefit (Critical Illness Cover) (in ‘): <Amount>
Accidental Death Benefit Term in years: <ADB Term> years
Premium Instalment (in ‘) : <Amount>
Payment frequency: <Payment Frequency>
Next premium due date : <Date>
You need to pay premiums for: PPT in years
Policy Term : <Policy Term> years
Policy end date: <Date of Maturity>
In case of any discrepancies in the above details please inform us immediately.

About the Advisor

Name : <Advisor Name>
Code / License Number : <Advisor Code>
Contact Number : <Advisor Contact>
Address : <Advisor address>

You may contact your advisor for any queries you have or any clarifications that you require in relation to the Policy Terms and conditions or any policy servicing requirements.

2. **YOUR FREE LOOK PERIOD**
You have an option to review the policy within <15/30> days from the date you receive it. In this period, if you are not satisfied with the policy terms and conditions, you can return the policy to us with reasons for cancellation. We will refund the premium paid after deduction of Stamp duty, proportionate risk premium and expenses for medical tests if any.

3. MAKING A CLAIM
You can contact Us on 1-860-266-7766 for any claims to be made under the policy and we will assist the claimant through the entire process.
In case of any queries or clarifications required, please feel free to contact your advisor or reach us at any of our service centres mentioned below. We will be happy to assist you. Warm regards,

<<< Authorised Signatory >>>

Visit us at

<<< Designation >>> www.iciciprulife.com

Write to us at: Email us at: Customer Service Helpline
ICICI Prudential Life Insurance Co. Ltd. lifeline@iciciprulife.com 1860 266 7766
Ground Floor & Upper Basement,
Unit No. 1A & 2A, Raheja Tipco Plaza,
Rani Sati Marg, Malad (East),Mumbai- 400097
Maharashtra.

ICICI Prudential Life Insurance Co. Ltd. Registered Address: ICICI Pru Life Towers,
1089, Appasaheb Marathe Marg, Prabhadevi, Mumbai-400025.
Reg No:105. Insurance is the subject matter of the solicitation.
Unique Identification Number as specified by IRDAI 105N151V08

Policy Schedule ICICI Pru iProtect Smart (UIN: 105N151V08)
(This is a Non-Linked Non-Par Life Individual pure risk premium product)

Policy Preamble

This Policy is the evidence of a contract between ICICI Prudential Life Insurance Company Limited (Us/We/Company) and the Policyholder (You) referred to below.

We have issued this Policy on the basis of the details provided by You in the Proposal Form submitted along with the required declarations, personal statement, applicable medical reports, the first premium deposit and any other information and documentation which constitute evidence of the insurability of the Life Assured for the issuance of the Policy.

We agree to provide the benefits set out in this Policy subject to its terms and conditions.

Policy Schedule

Name of the Life Assured:

Address:	Category: Medical/Non-Medical		
Date of Birth:	Age (Years):	Gender: M/F/T	Age Admitted: Y/N

Name of the Policyholder:

Policy No:	Benefit Option:

Policy Issue Date:	Date of Maturity:
Policy Acceptance Date:	Policy Term in years:

Premium Payment Term in years:	Periodicity of payment of premium (premium frequency):
Premium payment option:	Accelerated Critical Illness Benefit Term in years:
Total instalment premium (Rs.):	Accelerated Critical Illness Benefit (Rs.):
Sum Assured (Rs.):	Policy sourced by Distance Mode: Y/N
Accidental Death Benefit (Rs.):	Accidental Death Benefit Term in years:

Death Benefit Payout Option:	Due date of last premium payable:

Option	Sum Assured payable
Lump sum	
Income	
Increasing Income	

Nominee(s) Name	Gender	Nominee's Age	Percentage Share	Relationship to the Life Assured	Appointee Name [in case the Nominee is a minor]	Appointee's Gender	Appointee's Age	Relationship of the appointee with the Life Assured

Goods and Services Tax and/or cesses would be charged extra, as applicable.

Policy Schedule, terms and conditions of the Policy and the endorsements by Us, if any, shall form an integral part of this contract and shall be binding on Us and You.

The Policy shall stand cancelled by Us, without any further notice, in the event of dishonour of the first premium deposit.

Please immediately inform Us about any change in address or contact details.

Signed for and on behalf of the ICICI Prudential Life Insurance Company Limited, at Head Office, Mumbai on ……. (Issue Date)

<<<Authorised Signatory >>>

<<<Designation>>>

Version ……

Stamp duty of Rs. …….. (Rupees …….Only) paid by Pay order, vide receipt no. …… dated ……...

This is an output of a digitally signed print file

Please examine the policy and approach Us immediately in case of any discrepancies.

PART B

Definitions

1. Age means age at last birthday.
2. Accident means a sudden, unforeseen and involuntary event caused by external, visible and violent means.
3. Accelerated Critical Illness Benefit (ACI Benefit) means the benefit, which is payable upon the Life Assured being diagnosed on first occurrence of any of the covered 34 Critical Illnesses.
4. Annualized Premium means the premium amount payable in a year chosen by the policyholder, excluding the taxes, rider premiums, underwriting extra premiums and loadings for modal premiums, if any.
5. Appointee means the person appointed by You to receive the benefits payable under the Policy till Your Nominee is a minor.
6. Death Benefit means the benefit, which is payable on death or diagnosis of Terminal Illness as specified in the Policy Document.
7. Death Benefit Payout Option is the manner in which the Nominee receives the Death Benefit payable under the Policy.
8. Claimant means the person entitled to receive the Policy benefits and includes You, the nominee, the assignee, the legal heir, the legal representative(s) or the holder(s) of succession certificate as the case may be.
9. Date of commencement of risk is later of Policy Issue Date or Policy Acceptance Date
10. Date of Maturity means the date specified in the Policy Schedule on which the term of the Policy ends.
11. Distance Mode means every activity of solicitation (including lead generation) and sale of insurance products through the following modes: (i) voice mode, which includes telephone-calling (ii) short messaging service (SMS) (iii) electronic mode which includes e-mail, internet and interactive television (DTH) (iv) physical mode which includes direct postal mail and newspaper and magazine inserts and (v) solicitation through any means of communication other than in person.
12. Hospital A hospital means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) and the said act Or complies with all minimum criteria as under:
    a. has qualified nursing staff under its employment round the clock;
    b. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
    c. has qualified medical practitioner(s) in charge round the clock;
    d. has a fully equipped operation theatre of its own where surgical procedures are carried out;
    e. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;
13. Insured event is the event on the happening of which, benefits under Your policy become payable.
14. Life Assured means the person named in the Policy Schedule on whose life the Policy has been issued.
15. Limited Pay means premiums need to be paid regularly for a limited portion of the Policy Term.
16. Medical Practitioner is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of licence The Medical Practitioner should neither be the insured person(s) himself nor related to the insured person(s) by blood or marriage.
17. Nominee means the person named in the Policy Schedule who has been nominated by You to receive benefits in respect of this Policy.
18. Policy means the contract of Insurance entered into between You and Us as evidenced by the "Policy document".
19. Policy Acceptance Date means the date as specified in the Policy Schedule, from which the policy was effected.

20. Policy document means this document, the Proposal Form, the Policy Schedule and any additional information/document(s) provided to Us in respect of the Proposal Form, and any endorsement issued by Us.
21. Policy Issue Date means the date as specified in the Policy Schedule.
22. Policyholder or the Proposer or You or Your means the owner of the Policy at any point of time.
23. Policy Term means the period between the Policy Acceptance Date and the Date of Maturity specified in the Policy Schedule.
24. Policy Schedule means the policy schedule and any endorsements attached to and forming part of this Policy.
25. Premium means the instalment premium in case of Regular Pay and Limited Pay or single premium in case of Single Pay specified in the Policy Schedule which is payable/has been received under the Policy.
26. Pre-existing Disease means any condition, ailment, injury or disease:
    i. that is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the Company or its revival or
    ii. For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy or its revival.
27. Premium Payment Term means the period specified in the Policy Schedule during which Premium is payable.
28. Proposal Form means a form to be completed by You for availing an insurance policy, and to furnish all Material information required by Us to assess risk and to decline or to undertake the risk, and in the event of acceptance of risk, to determine the rates, advantages, terms and conditions of a cover to be granted.
    Explanation: "Material" shall mean and include all important, essential and relevant information that enables Us to take an informed decision while underwriting the risk.
29. Regulator means the authority that has regulatory jurisdiction and powers over Us. Currently the Regulator is the Insurance Regulatory and Development Authority of India (IRDAI).
30. Regular Pay means premiums need to be paid regularly throughout the Policy Term.
31. Revival of the Policy means restoration of Policy benefits.
32. Revival period means the period of five consecutive years from the due date of the first unpaid premium and before the termination date of the Policy, during which period You are entitled to revive the policy.
33. Sum Assured means the amount specified in the Policy Schedule.
34. Surrender means complete withdrawal/termination of the Policy by You.
35. Total Premiums Paid means the total of all premiums received, excluding any extra premium, any rider premium and taxes.
36. Unexpired risk premium value means an amount, if any, that becomes payable in case of surrender or discontinuance of premium in single/ limited pay policies in accordance with the terms and conditions of the Policy.
37. You or Your means the Policyholder of the Policy at any point of time.
38. We or Us or Our or Company means ICICI Prudential Life Insurance Company Limited.

PART C

1. Benefits available under the policy:

1.1 Death Benefit

We shall pay the Death Benefit as per the Death Benefit Payout Option stated on Your Policy Schedule upon diagnosis of Terminal Illness or death of the Life Assured whichever is earlier provided the Policy is in force as on the date of diagnosis of Terminal Illness or the date of death of the Life Assured. A Life Assured shall be regarded as "Terminally Ill" only if that Life Assured is diagnosed as suffering from a condition which, in the opinion of two independent Medical Practitioners, specializing in treatment of such illness, is highly likely to lead to death within 6 months. The terminal illness must be diagnosed and confirmed by Medical Practitioners registered with Indian Medical Association and approved by Us. We reserve the right for independent assessment of the Terminal Illness. Death Benefit would be as per the below table:

Premium Payment Option	Death Benefit
Regular Pay and Limited Pay	Higher of 7 times the annualized premium or 105% of the total premiums received up to the date of death or the sum assured as stated on your policy schedule to be paid on death.

a. The Death Benefit will reduce by the extent of the ACI Benefit claim paid if the Death Benefit is higher than the ACI Benefit. ACI Benefit is as explained in section 1.4 below.
b. The Policy shall terminate upon payment of the Death Benefit.
c. The Death Benefit amount may be taxable as per the prevailing tax laws.

1.2 Waiver of Premium on Permanent Disability due to accident

a. Upon the diagnosis of Permanent Disability (as defined below) of the Life Insured which arises due to an Accident, We shall waive all future premiums payable for all benefits under the Policy during the remaining Premium Payment Term of the Policy provided the Policy is in force as on the date of diagnosis of Permanent Disability of the Life Assured.

b. The Policy will continue for the Death Benefit, Accidental Death Benefit and the Accelerated Critical Illness Benefit.

For the purpose of this benefit, "and Permanent Disability" means the inability of the Life Assured to perform at least 3 of the following 6 activities of daily work:

- Mobility: The ability to walk a distance of 200 meters on flat ground.
- Bending: The ability to bend or kneel to touch the floor and straighten up again and the ability to get into a standard saloon car, and out again.
- Climbing: The ability to climb up a flight of 12 stairs and down again, using the handrail if needed.
- Lifting: The ability to pick up an object weighing 2kg at table height and hold for 60 seconds before replacing the object on the table.
- Writing: The manual dexterity to write legibly using a pen or pencil, or type using a desktop personal computer keyboard.

- Blindness: The permanent and irreversible loss of sight to the extent that even when tested with the use of visual aids, vision is measured at 3/60 or worse in the better eye using a Snellen eye chart.

c. Provided that the disability should have lasted for at least 180 days without interruption from the date of disability and must be deemed permanent by a Company empanelled Medical Practitioner. In the event of death of the insured within the above period, the policy shall terminate on payment of applicable benefits and all rights, benefits and interests under the policy shall stand extinguished.

d. In case of incidences covered under accidental Permanent Disability as well as Critical Illness, benefits shall be paid out under both the options.

1.3 Accidental Death (AD) Benefit

a. In the event of the Life Assured's death due to an Accident, where both Accident and death occur during the Accidental Death Benefit Term, the Accidental Death Benefit as mentioned on the Policy Schedule will be payable by Us forthwith as a lump sum subject to the terms and conditions below. This is an additional benefit and will be paid in addition to the Death Benefit.
b. The Accident shall result in bodily injury or injuries to the Life Assured independently of any other means. Such injury or injuries shall, within 180 days of the occurrence of the Accident, directly and independently of any other means cause the death of the Life Assured before the expiry of the Accidental Death Benefit cover. In the event of the death of the Life Assured after 180 days of the occurrence of the Accident, the Company shall not be liable to pay the Accidental Death Benefit. The benefit will be payable if the accident occurs within the Accidental Death Benefit Term even if the death occurs beyond the Accidental Death Benefit Term (however within 180 days of the accident).
c. The Policy must be in full force at the time of Accident.
d. The Company shall not be liable to pay this benefit in case the accident and subsequent death of the Life Assured occurs after the accidental death benefit term.
e. Upon payment of the Accidental Death Benefit, the Policy will terminate and all rights, benefits and interests under the Policy will stand extinguished.
f. In case no AD Benefit is triggered within the AD Benefit term, then AD Benefit will terminate and premiums corresponding to it will not be payable. However You would be required to pay premiums for all other Benefits to keep the policy in force.

1.4 Accelerated Critical Illness (ACI) Benefit

a. We shall pay the ACI Benefit upon the Life Assured being diagnosed on first occurrence of any of the covered 34 Critical Illnesses defined below within ACI Benefit term, provided the Policy is in force as on the date of diagnosis of Critical Illness of the Life Assured.
b. Once ACI Benefit is triggered,
    - If ACI Benefit is less than the Death Benefit the policy will continue with a reduced Death Benefit by the extent of ACI Benefit paid. Premium payment on account of ACI Benefit will cease after payout of ACI Benefit. The future premiums for Death Benefit will reduce proportionately.
    - If ACI Benefit is equal to the Death Benefit the policy will terminate.
    - The benefit is payable irrespective of the actual expenses incurred by the policyholder.

c. In case of Angioplasty: ACI Benefit payable is subject to a maximum of Rs. 5,00,000. On payment of Angioplasty,
   - The policy will continue for other covered CIs with ACI Benefit reduced by Angioplasty payout and future premiums for ACI benefit reduced proportionately and
   - The Policy will continue with Death Benefit reduced by Angioplasty payout, and future premiums for Death Benefit will reduce proportionately.

d. In case of incidences covered under accidental Permanent Disability as well as Critical Illness, benefits shall be paid out under both the options.

e. In case no ACI Benefit is triggered within the ACI Benefit term, then ACI Benefit will terminate and premiums corresponding to it will not be payable. However You would be required to pay premiums for all other Benefits to keep the policy in force.

Waiting Period for Accelerated Critical Illness Benefit

a. The ACI benefit shall not apply or be payable in respect of any Critical Illness for which care, treatment or advice was recommended by or received from a Physician, or which first manifested itself or was contracted during the first six months from the date of commencement of risk or three months from the policy revival date where the policy has lapsed for more than three months.

b. In the event of occurrence of any of the scenarios mentioned in 'a' above, or in case of a death claim, where it is established that the Life Assured was diagnosed to have any one of the covered critical illness during the waiting period for which a critical illness claim could have been made, the Company will refund the premiums corresponding to the ACI Benefit from date of commencement of risk of the policy or from the date of revival as applicable and the ACI Benefit will terminate with immediate effect.

c. No waiting period applies where the Critical Illness arises due to an Accident.

For the purpose of the ACI Benefit, "Critical Illness" means any of the following listed illnesses or procedures:

1. Cancer of Specified Severity:

A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.

The following are excluded –

1. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN-2 and CIN-3.
2. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
3. Malignant melanoma that has not caused invasion beyond the epidermis;
4. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0

5. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
6. Chronic lymphocytic leukaemia less than RAI stage 3
7. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
8. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

2. Open Chest CABG:

The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

Excluded are:
Angioplasty and/or any other intra-arterial procedures

3. Myocardial Infarction (First Heart Attack of Specified Severity):

The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

1. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
2. New characteristic electrocardiogram changes
3. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded:

1. Other acute Coronary Syndromes
2. Any type of angina pectoris
3. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

4. Heart Valve Surgery (Open Heart Replacement or Repair of Heart Valves):

The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

5. Surgery to aorta

The actual undergoing of major surgery to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen. For

the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches.

6. Cardiomyopathy

An impaired function of the heart muscle, unequivocally diagnosed as Cardiomyopathy by a Registered Medical Practitioner who is a cardiologist, and which results in permanent physical impairment to the degree of New York Heart Association classification Class III or Class IV, or its equivalent, based on the following classification criteria:
Class III - Marked functional limitation. Affected patients are comfortable at rest but performing activities involving less than ordinary exertion will lead to symptoms of congestive cardiac failure.
Class IV - Inability to carry out any activity without discomfort. Symptoms of congestive cardiac failure are present even at rest. With any increase in physical activity, discomfort will be experienced. The Diagnosis of Cardiomyopathy has to be supported by echographic findings of compromised ventricular performance. Irrespective of the above, Cardiomyopathy directly related to alcohol or drug abuse is excluded.

7. Primary (Idiopathic) Pulmonary hypertension

An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

The NYHA Classification of Cardiac Impairment are as follows:

a. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
b. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

8. Angioplasty

Coronary Angioplasty is defined as percutaneous coronary intervention by way of balloon angioplasty with or without stenting for treatment of the narrowing or blockage of minimum 50 % of one or more major coronary arteries. The intervention must be determined to be medically necessary by a cardiologist and supported by a coronary angiogram (CAG).

Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery.

Diagnostic angiography or investigation procedures without angioplasty/stent insertion are excluded.

9. Blindness

Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident.

The Blindness is evidenced by:

a. corrected visual acuity being 3/60 or less in both eyes or ;
b. the field of vision being less than 10 degrees in both eyes.

The diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure.

10. End stage Lung Failure (Chronic Lung Disease):

End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:

1. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
2. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
3. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO2 < 55mmHg); and
4. Dyspnea at rest.

11. End stage liver failure (Chronic Liver Disease):

Permanent and irreversible failure of liver function that has resulted in all three of the following:

1. Permanent jaundice; and
2. Ascites; and
3. Hepatic encephalopathy.

Liver failure secondary to drug or alcohol abuse is excluded.

12. Kidney Failure Requiring Regular Dialysis:

End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

13. Major Organ/ Bone Marrow Transplant

The actual undergoing of a transplant of:

i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or

ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

iii. The following are excluded:

a. Other stem-cell transplants

b. Where only islets of langerhans are transplanted

14. Apallic Syndrome:

Universal necrosis of the brain cortex, with the brain stem intact. Diagnosis must be definitely confirmed by a Registered Medical practitioner who is also a neurologist holding such an appointment at an approved hospital. This condition must be documented for at least one (1) month.

15. Benign Brain Tumour:

Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.

This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.

1. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
2. Undergone surgical resection or radiation therapy to treat the brain tumor.

The following conditions are excluded:
Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord.

16. Brain Surgery

The actual undergoing of surgery to the brain, under general anaesthesia, during which a Craniotomy is performed. Burr hole and brain surgery as a result of an accident is excluded. The procedure must be considered necessary by a qualified specialist and the benefit shall only be payable once corrective surgery has been carried out.

17. Coma of Specified Severity:

A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

- no response to external stimuli continuously for at least 96 hours;
- life support measures are necessary to sustain life; and
- permanent neurological deficit which must be assessed at least 30 days after the onset of the coma

The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

18. Major Head Trauma

Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.

The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word "permanent" shall mean beyond the scope of recovery with current medical knowledge and technology.

The Activities of Daily Living are:

1. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
2. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
3. Transferring: the ability to move from a bed to an upright chair orwheelchair and vice versa;
4. Mobility: the ability to move indoors from room to room on level surfaces;
5. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
6. Feeding: the ability to feed oneself once food has been prepared and made available.

The following are excluded:

1. Spinal cord injury;

19. Permanent Paralysis of Limbs

Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

20. Stroke resulting in permanent symptoms

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.
The following are excluded:

- Transient ischemic attacks (TIA)
- Traumatic injury of the brain
- Vascular disease affecting only the eye or optic nerve or vestibular functions.

21. Alzheimer's Disease

Alzheimer's (presenile dementia) disease is a progressive degenerative disease of the brain, characterised by diffuse atrophy throughout the cerebral cortex with distinctive histopathological changes. It affects the brain, causing symptoms like memory loss, confusion, communication problems, and general impairment of mental function, which gradually worsens leading to changes in personality.
Deterioration or loss of intellectual capacity, as confirmed by clinical evaluation and imaging tests, arising from Alzheimer's disease, resulting in progressive significant reduction in mental and social functioning, requiring the continuous supervision of the Insured Person. The diagnosis must be supported by the clinical confirmation of a Neurologist and supported by Our appointed Medical Practitioner.
The disease must result in a permanent inability to perform three or more Activities of daily living with Loss of Independent Living" or must require the need of supervision and permanent presence of care staff due to the disease. This must be medically documented for a period of at least 90 days

The following conditions are however not covered:
a. neurosis or neuropsychiatric symptoms without imaging evidence of Alzheimer's Disease
b. alcohol related brain damage; and
c. any other type of irreversible organic disorder/dementia not associated with Alzheimer's Disease

The Activities of Daily Living are:
i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
iv. Mobility: the ability to move indoors from room to room on level surfaces;
v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
vi. Feeding: the ability to feed oneself once food has been prepared and made available

22. Motor Neurone Disease with permanent symptoms

Motor neurone disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anteriorhorn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

23. Multiple Sclerosis with Persisting Symptoms

The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

1. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
2. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

Other causes of neurological damage such as SLE are excluded.

24. Muscular Dystrophy

Diagnosis of muscular dystrophy by a Registered Medical Practitioner who is a neurologist based on three (3) out of four (4) of the following conditions:
(a) Family history of other affected individuals;
(b) Clinical presentation including absence of sensory disturbance, normal cerebro-spinal fluid and mild tendon reflex reduction;
(c) Characteristic electromyogram; or
(d) Clinical suspicion confirmed by muscle biopsy.

The condition must result in the inability of the Life Assured to perform (whether aided or unaided) at least three (3) of the six (6) 'Activities of Daily Living' as defined, for a continuous period of at least six (6) months.

25. Parkinson's Disease

Unequivocal Diagnosis of Parkinson's Disease by a Registered Medical Practitioner who is a neurologist where the condition:
(a) cannot be controlled with medication;
(b) shows signs of progressive impairment; and
(c) Activities of Daily Living assessment confirms the inability of the Insured to perform at least three (3) of the Activities of Daily Living as defined in the Policy, either with or without the use of mechanical equipment, special devices or other aids or adaptations in use for disabled persons.

Drug-induced or toxic causes of Parkinson's disease are excluded.

26. Poliomyelitis

The occurrence of Poliomyelitis where the following conditions are met:
1. Poliovirus is identified as the cause and is proved by Stool Analysis,
2. Paralysis of the limb muscles or respiratory muscles must be present and persist for at least 3 months.

27. Loss of Independent Existence

The insured person is physically incapable of performing at least three (3) of the "Activities of Daily Living" as defined below (either with or without the use of mechanical equipment, special devices or other aids or adaptations in use for disabled persons) for a

continuous period of at least six (6) months, signifying a permanent and irreversible inability to perform the same. For the purpose of this definition, the word "permanent" shall mean beyond the hope of recovery with current medical knowledge and technology. The Diagnosis of Loss of Independent Existence must be confirmed by a Registered Doctor Who is a specialist.

Only Life Insured with Insurance Age between 18 and 74 on first diagnosis is eligible to receive a benefit under this illness.

Activities of Daily Living:

1. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
2. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
3. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
4. Mobility: the ability to move indoors from room to room on level surfaces;
5. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
6. Feeding: the ability to feed oneself once food has been prepared and made available.

28. Loss of Limbs

The physical separation of two or more limbs, at or above the wrist or ankle level limbs as a result of injury or disease. This will include medically necessary amputation necessitated by injury or disease. The separation has to be permanent without any chance of surgical correction. Loss of Limbs resulting directly or indirectly from self-inflicted injury, alcohol or drug abuse is excluded.

29. Deafness

Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means "the loss of hearing to the extent that the loss is greater than 90decibels across all frequencies of hearing" in both ears.

30. Loss of Speech

Total and irrecoverable loss of the ability to speak as a result of injury or disease to the Vocal Cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by an Ear, Nose, and Throat (ENT) specialist.

31. Medullary Cystic Disease

Medullary Cystic Disease where the following criteria are met:

a)the presence in the kidney of multiple cysts in the renal medulla accompanied by the presence of tubular atrophy and interstitial fibrosis;
b) clinical manifestations of anaemia, polyuria, and progressive deterioration in kidney function; and
c)the Diagnosis of Medullary Cystic Disease is confirmed by renal biopsy.
Isolated or benign kidney cysts are specifically excluded from this benefit.

32. Systematic lupus Eryth. with Renal Involvement

Multi-system, autoimmune disorder characterized by the development of auto-antibodies, directed against various self-antigens. For purposes of the definition of "Critical Illness", SLE is restricted to only those forms of systemic lupus erythematosus, which involve the kidneys and are characterized as Class III, Class IV, Class V or Class VI lupus nephritis under the Abbreviated International Society of Nephrology/Renal Pathology Society (ISN/RPS) classification of lupus nephritis (2003) below based on renal biopsy. Other forms such as discoid lupus, and those forms with only hematological and joint involvement are specifically excluded.
Abbreviated ISN/RPS classification of lupus nephritis (2003):
Class I - Minimal mesangial lupus nephritis
Class II - Mesangial proliferative lupus nephritis
Class III - Focal lupus nephritis
Class IV - Diffuse segmental (IV-S) or global (IV-G) lupus nephritis
Class V - Membranous lupus nephritis
ClassVI - Advanced sclerosing lupus nephritis the final diagnosis must be confirmed by a certified doctor specialising in Rheumatology and Immunology.

33. Third degree burns (Major Burns):

There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

34. Aplastic Anaemia

Irreversible persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least two (2) of the following:
(a) Blood product transfusion;
(b) Marrow stimulating agents;
(c) Immunosuppressive agents; or
(d) Bone marrow transplantation.
The Diagnosis of aplastic anaemia must be confirmed by a bone marrow biopsy. Two out of the following three values should be present:
- Absolute Neutrophil count of 500 per cubic millimetre or less;
- Absolute Reticulocyte count of 20,000 per cubic millimetre or less; and
- Platelet count of 20,000 per cubic millimetre or less.

1.5 Life Stage Protection

You can choose to increase the Death Benefit at the key milestones of marriage and child birth/ adoption of child, provided no claim has been admitted for any benefits under the policy and the policy is in force.

The Death Benefit can be increased without any medicals on any one or all of the below events during the term of the Policy. This feature is available to a Life Assured underwritten as a standard life at the time of inception of the Policy per the Board Approved Underwriting Policy.

Event	Additional Death Benefit (percentage of original Sum Assured)	Subject to maximum additional Death Benefit
Marriage	50%	Rs. 50,00,000
Birth / Legal adoption of 1st child	25%	Rs. 25,00,000
Birth / Legal adoption of 2nd child	25%	Rs. 25,00,000

On exercising the option, You will have to pay an additional premium for the additional Sum Assured for the outstanding term of the policy based on your then age. Hence the future premium payable by You on exercising this option will be the sum of original premium and additional premium.
No fee is chargeable for this option.

This feature is available only with Regular premium payment option. Such increase in sum assured is only applicable to base death benefit. The ACI Benefit and AD Benefit will remain unchanged. Premium will be recalculated based on the increased Death Sum Assured and outstanding policy term. This is subject to:

1. Minimum policy term (which is 5 years) available at the time of the exercising this feature.
2. The Life Assured being less than 50 years of age at the time of the event.

Such increase needs to be exercised within 6 months of the event and will be effective from the next policy anniversary. The additional premium will also be payable from next policy anniversary.

1.6 Death Benefit Payout Options

The Death Benefit will be payable as per one of the below options chosen by You at the inception of Your policy and mentioned in Your Policy Schedule.

1. Lump Sum Option – Entire Death Benefit amount is payable as lump sum.
2. Income Option – 10% of the Death Benefit amount is payable every year for 10 years. This will be payable in equal monthly instalments in advance at the rate of 0.83333% of Death Benefit amount.

   The beneficiary can also advance the first year's income as a lump sum. The monthly income will then continue from the subsequent month for next 9 years advance at the rate of 0.80% of Death Benefit amount.
3. Lump sum and Income – The part of the Death Benefit amount to be paid out as lump sum is chosen at inception. The balance Death Benefit amount will be paid out in equal monthly instalments in advance at the rate of 0.83333% per month over 10 years.
4. Increasing Income Option – Benefit amount is payable in monthly instalments for 10 years starting with 10% of the benefit amount per annum in the first year. The income amount will increase at 10% p.a. simple interest every year thereafter.

For options 2, 3, and 4, You or the nominee as the case may be, will have an option to take the discounted value of the future payouts anytime during the payout term by informing Us of this decision in writing. The present value will be derived using discount rate of 4% p.a..

1.7 Smart Exit Benefit

You have an option to cancel the Policy and receive Smart Exit Benefit, equal to Total Premiums Paid under the Policy. No additional premium is payable to avail this option.

The following conditions are applicable for availing Smart Exit benefit:

- The Sum Assured in the policy at inception is ₹ 6,000,000 or above.
- This option can be exercised in any policy year greater than 25 but not during the last 5 policy years, provided the age of the life assured is 60 years or more at the time of exercise.
- The Policy is in-force with all due premiums paid at the time of exercising this option.
- No claim for any of the underlying benefits has been registered and is under evaluation/ or accepted/ or paid/ being paid on the Policy.

The Policy shall terminate on payment of this benefit (if exercised) and all rights, benefits and interests under this Policy will stand extinguished. You can either opt for Smart Exit Benefit or Unexpired Risk Premium Value as per Clause 3, Part D, i.e. you cannot avail both the benefits simultaneously.

Where Life Stage Protection options has been exercised, Total Premiums Paid includes Premium paid for each tranche of additional sum assured purchased. In case the benefit term for additional benefit(s) (which are benefits other than as mentioned in Part C, Clause 1.1 and 1.2) has expired at the time of exercise of Smart Exit Benefit, then Total Premiums Paid shall exclude the Premium Paid towards such additional benefit(s).

2. Premium payment:

i. You are required to pay Premiums on the due dates and for the amount mentioned in the Policy Schedule.

ii. The grace period for payment of premium is 15 days for monthly frequency of premium payment and 30 days for other frequencies of premium payment. In case of occurrence of the covered events during the grace period, We will pay the benefits as per the terms and conditions of the Policy.

iii. If any premium instalment is not paid within the grace period then the Policy shall lapse and all cover under the Policy will cease.

iv. You are required to pay Premiums for the entire Premium Payment Term.

v. We are not under any obligation to remind You about the premium due date, except as required by applicable regulations.

vi. The loading based on premium paying modes are mentioned below:

Premium frequency	Loading as a % of Premium
Yearly	NA
Half-yearly	1.25%
Monthly	2.50%

vii. You may pay Premium through any of the following modes:

a) Cash
b) Cheque

c) Demand Draft
d) Pay Order
e) Banker's cheque
f) Internet facility as approved by the Company from time to time
g) Electronic Clearing System / Direct Debit
h) Credit or Debit cards held in your name

viii. Amount and modalities will be subject to our rules and relevant legislation or regulation
ix. Any payment made towards first or renewal premium is deemed to be received by Us only when it is received at any of Our branch offices or authorized collection points and after an official printed receipt is issued by Us.
x. No person or individual or entity is authorized to collect cash or self-cheque or bearer cheque on Our behalf.
xi. Cheque or demand drafts must be drawn only in favour of ICICI Prudential Life Insurance Company Limited.
xii. Please ensure that You mention the application number for the first premium deposit and the policy number for the renewal premiums on the cheque or demand draft.
xiii. Where Premiums have been remitted otherwise than in cash, the application of the Premiums received will be conditional on the realization of the proceeds of the instrument of payment, including electronic mode.
xiv. If You suspend payment of premium for any reason whatsoever, We will not be held liable. In such an event, benefits, if any, will be available only in accordance with the Policy terms and conditions.
xv. Premiums need to be paid only for the chosen premium payment term. Once premiums have been paid for the premium payment term, the policy benefits will continue for the term of the policy.

3. Maturity/Survival Benefit:

No benefit will be payable upon the maturity of the Policy. At the end of the Policy Term, the Policy will automatically terminate and all rights, benefits and interests under the Policy will stand extinguished.

6. Grace Period

If you are unable to pay an instalment premium by the due date, you will be given a grace period of 15 days for payment of due instalment premium if You have chosen monthly frequency, and 30 days for payment of due instalment premium if You have chosen any other frequency, commencing from the premium due date. The life cover continues during the grace period. In case of death of Life Assured during the grace period, We will pay the applicable Death Benefit.

PART D

1. Free look Period (15/30 days refund policy)

You have an option to review the Policy following receipt of the Policy Document. If you are not satisfied with the terms and conditions of this Policy, please return the Policy Document to Us for cancellation with reasons within

i. 15 days from the date you received it, if your Policy is not purchased through Distance Mode
ii. 30 days from the date you received it, if your Policy is an electronic policy or is purchased through Distance Mode.

On cancellation of the Policy during the freelook period, We will return the premium paid subject to the following deductions:

i. Proportionate risk premium for the period of cover
ii. Stamp duty under the Policy
iii. Expenses borne by the Company on medical examination, if any

The Policy shall terminate on payment of this amount and all rights, benefits and interests under this Policy will stand extinguished.

2. Paid-up Value

There is no paid-up value under this Policy.

3. Unexpired risk premium value

For Limited Pay policies:

i. Unexpired risk premium value, if any, will be payable if the policy holder voluntarily terminates the policy during the policy term
Or for lapsed policies on earlier of:

- Death of the Life Assured within the revival period, or
- At the end of the revival period.

Unexpired risk premium value = (Unexpired risk premium value factor/100) X Annual Premium
Unexpired risk premium value factors are given in Annexure I

ii. The Policy will terminate on payment of this amount and all the rights / title and interest under the Policy shall stand extinguished.
iii. Unexpired risk premium value may be taxable as per the prevailing tax laws.

For Regular Pay policies:
No unexpired risk premium value is payable for Regular Pay policies.

4. Exclusions

4.1 For Waiver of Premium on Permanent Disability due to accident the following exclusions shall apply:

i. We will not be liable to provide the Waiver of Premium on Permanent Disability benefit if the Permanent Disability is directly or indirectly due to or caused, occasioned, accelerated or aggravated by, any one of the following:

- Attempted suicide or self-inflicted injuries while sane or insane, or whilst the Life Assured is under the influence of any narcotic substance or drug or intoxicating liquor except under the direction of a medical practitioner; or
- Engaging in aerial flights (including parachuting and skydiving) other than as a fare paying passenger or crew on a licensed passenger-carrying commercial aircraft operating on a regular scheduled route; or
- The Life Assured with criminal intent committing any breach of law; or
- Due to war, whether declared or not or civil commotion; or
- Engaging in hazardous sports / pastimes, i.e. taking part in (or practising for) boxing, caving, climbing, horse racing, jet skiing, martial arts, mountaineering, off piste skiing, pot holing, power boat racing, underwater diving, yacht racing or any race, trial or timed motor sport.
- PD due to accident must be caused by violent, external and visible means.

ii. The accident shall result in bodily injury or injuries to the Life Assured independently of any other means. Such injury or injuries shall, within 180 days of the occurrence of the accident, directly and independently of any other means cause the PD of the Life Assured. In the event of PD of the Life Assured after 180 days of the occurrence of the accident, the Company shall not be liable to pay this benefit.

iii. The Company shall not be liable to pay this benefit in case PD of the Life Assured occurs after the date of termination of the policy.

4.2 For Accidental Death Benefit the following exclusions apply:

We will not be liable to pay the Accidental Death Benefit if the Accident is directly or indirectly due to or caused, occasioned, accelerated or aggravated by, any one of the following:

a) Attempted suicide or self-inflicted injuries while sane or insane, or whilst the Life Assured is under the influence of any narcotic substance or drug or intoxicating liquor except under the direction of a medical practitioner; or

b) Engaging in aerial flights (including parachuting and skydiving) other than as a fare paying passenger or crew on a licensed passenger-carrying commercial aircraft operating on a regular scheduled route; or

c) The Life Assured with criminal intent, committing any breach of law; or

d) Due to war, whether declared or not or civil commotion; or

e) Engaging in hazardous sports or pastimes, e.g. taking part in (or practising for) boxing, caving, climbing, horse racing, jet skiing, martial arts, mountaineering, off piste skiing, pot holing, power boat racing, underwater diving, yacht racing or any race, trial or timed motor sport.

4.3 For ACI Benefit the following exclusions apply:

We will not be liable to pay any ACI Benefit in respect of any listed condition arising directly or indirectly from, though, in consequence of or aggravated by any of the following:

a) Pre-Existing Conditions or conditions connected to a Pre-Existing Condition will be excluded. Pre-existing Disease means any condition, ailment, injury or disease:
   i. that is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the Company or its revival or

ii. For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy or its revival.

b) Existence of any Sexually Transmitted Disease (STD) and its related complications
c) Self-inflicted injury, suicide, insanity and deliberate participation of the life insured in an illegal or criminal act with criminal intent.
d) Use of intoxicating drugs / alcohol / solvent, taking of drugs except under the direction of a qualified medical practitioner.
e) War – whether declared or not, civil commotion, breach of law with criminal intent, invasion, hostilities (whether war is declared or not), rebellion, revolution, military or usurped power or wilful participation in acts of violence.
f) Aviation other than as a fare paying passenger or crew in a commercial licensed aircraft.
g) Taking part in any act of a criminal nature with criminal intent.
h) Treatment for injury or illness caused by avocations / activities such as hunting, mountaineering, steeple-chasing, professional sports, racing of any kind, scuba diving, aerial sports, activities such as hand-gliding, ballooning, deliberate exposure to exceptional danger.
i) Radioactive contamination due to nuclear accident.
j) Failure to seek or follow medical advice, the Life assured has delayed medical treatment in order to circumvent the waiting period or other conditions and restriction applying to this policy.
k) Any treatment of a donor for the replacement of an organ.
l) Any illness due to a congenital defect or disease which has manifested or was diagnosed before the Insured attains aged 17.

i. Loan

We will not provide loans under this Policy.

j. Riders

Riders may be offered but only subject to prior approval of the Regulator.

k. Revival

A Policy which has lapsed for non-payment of premium within the grace period may be revived subject to underwriting and the following conditions:

a) The application for revival is made within 5 years from the due date of the first unpaid premium and before the termination date of the Policy. Revival will be based on the prevailing Board approved underwriting policy.
b) You furnish, at your own expense, satisfactory evidence of health as required by Us.
c) The arrears of Premiums together with interest at such rate as We may charge for late payment of premiums are paid. The interest rate applicable in July 2023 is 8.59% p.a. compounded half yearly.
d) The revival of the Policy may be on terms different from those applicable to the Policy before it lapsed for example, extra mortality premiums or charges may be applicable subject to our Board approved underwriting policy.
e) We reserve the right to not revive the Policy. In that case, only the premiums paid towards the revival of the Policy shall be refunded without any interest.

f) For ACI Benefit, a waiting period of 3 months will be applicable for any revivals after 3 months from the due date of the first unpaid premium. No waiting period will be applicable for any revival within 3 months of the due date of the first unpaid premium.
g) The revival will take effect only if it is specifically communicated by Us to You.

l. To whom benefits are payable

Benefits are payable to the Policyholder or to the assignee(s) where an endorsement has been recorded in accordance with Section 38 of the Insurance Act, 1938, and as amended from time to time. In case of death of the Policyholder or assignee(s) as mentioned above, benefits are payable either to the Nominee(s) where a valid nomination has been registered by the Company (in accordance with section 39 of the Insurance Act, 1938, and as amended from time to time), or to the executors, administrators or other legal representatives who obtain representation to the estate of the Policyholder or to such person or persons as directed by a court of competent jurisdiction in India, limited at all times to the monies payable under this Policy.

If the Policyholder and Life Assured are different, then upon death of the Policyholder and subsequent intimation of the death with the Company, the policy shall vest on the Life Assured. Thereafter, the Life Assured shall become the Policyholder and will be entitled to all benefits and subject to all liabilities as per the terms and conditions of the policy. The Life Assured cum Policyholder can register due nomination as per Section 39 of the Insurance Act, 1938 as amended from time to time.

We hereby agree to pay the appropriate benefits under the Policy subject to:
a) Our satisfaction of the benefits having become payable on the happening of an event as per the Policy terms and conditions,
b) The title of the said person or persons claiming payment.

PART E – Not Applicable

PART F

General Conditions

1. Age

We have calculated the premiums under the Policy on the basis of the Age of the Life Assured as declared by You in the Proposal Form. In case if the age proof of the Life Assured was not submitted at the time of Proposal, You will be required to submit such an Age proof of the Life Assured acceptable to Us, and have the Age admitted.

If the Age of the life assured has been misstated, We will take one of the following actions:

a) If the Correct Age of the Life Assured makes him ineligible for this product, We will offer a suitable plan as per Our underwriting norms. If You do not wish to opt for the alternative plan or if it is not possible for Us to grant any other plan, We will cancel the Policy and refund the premiums paid (without interest) under the Policy after adjustment against the paid benefits. The Policy will terminate on the said payment.

b) If the Correct Age of the Life Assured makes him eligible for this Policy, revised Premium depending upon the Correct Age will be payable. Difference of premium from inception will be collected with interest, if age declared is higher and excess premium collected will be refunded without interest, if age is found to be lower.

The provisions of Section 45 of the Insurance Act, 1938, as amended from time to time shall be applicable.

2. Nomination

Nomination under the Policy will be governed by Section 39 of the Insurance Act, 1938, as amended from time to time. Please refer to Annexure II for details on this section.

3. Assignment

Assignment of the Policy will be governed by Section 38 of the Insurance Act, 1938, as amended from time to time. Please refer to Annexure III for details on this section.

4. Incontestability

Incontestability will be as per Section 45 of the Insurance Act, 1938, as amended from time to time. Please refer to Annexure IV for details on this section.

5. Misstatement & Fraud

Misstatement and Fraud will be as per Section 45 of the Insurance Act, 1938, as amended from time to time. Please refer to Annexure IV for details on this section.

The Policy is subject to the terms and conditions as mentioned in the Policy document and is governed by the Laws of India.

6. Communication address

Our communication address is:

Address:

Customer Service Desk
ICICI Prudential Life Insurance Company Limited,
Ground Floor & Upper Basement,
Unit No. 1A & 2A, RahejaTipco Plaza,
Rani Sati Marg, Malad (East),
Mumbai- 400097
Maharashtra.

Telephone: 1860 266 7766
Facsimile: 022 4205 8222
E-mail: lifeline@iciciprulife.com

We expect You to immediately inform Us about any change in Your address or contact details.

7. Electronic transactions

All transactions carried out by You through Internet, electronic, call centres, tele-service operations, computer, automated machines network or through other means of communication will be valid and legally binding on Us as well as You.

This will be subject to the relevant guidelines and terms and conditions as may be specified by Us.

8. Jurisdiction

The Policy is subject to the terms and conditions as mentioned in the Policy document and is governed by the laws of India.

Indian courts shall have exclusive jurisdiction over all differences or disputes arising in relation to this Policy.

9. Legislative changes

All benefits payable under the Policy are subject to the tax laws and other financial enactments as they exist from time to time.

The Policy terms and conditions may be altered based on any future legislative or regulatory changes.

10. Payment of claim

For processing a death claim under this Policy, We will require the following documents (as may be relevant):

For natural deaths:

a) Claimant's Statement
b) Original Policy Document
c) Death Certificate of the Life Assured issued by the local municipal authority
d) Cancelled Cheque for processing electronic payment
e) Claimant's Photo Identity proof and address proof
f) Medical cause of the death certificate issued by the last treating/ last attending doctor, if any
g) Medical records (Admission notes, Discharge Summary/Death summary, test reports etc., if any
h) Any other documents or information as may be required by the Company for processing of the claim depending on the cause of the death.

For unnatural deaths:

a) Claimant's Statement
b) Original Policy Document
c) Death Certificate of the Life Assured issued by the local municipal authority

d) Cancelled Cheque for processing electronic payment
e) Claimant's Photo Identity proof & address proof
f) Post Mortem report & viscera/ chemical analysis report
g) FIR report, final police investigation report, police panchnama/ Inquest report, driving license
h) Any other documents or information as may be required by the Company for processing of the claim depending on the cause of the death.

Claim payments are made only in Indian currency in accordance with the prevailing Exchange control regulations and other relevant laws and regulations in India. In case the Claimant is unable to provide any or all of the above documents, in exceptional circumstances such as a natural calamity, the Company may at its own discretion conduct an investigation and may subsequently settle the claim.

11. Suicide

If the Life Assured, whether sane or insane, commits suicide within 12 months from the date of commencement of risk of this Policy, We will refund higher of 80% of the total premiums paid, if any till the date of death or unexpired risk premium value as available on the date of death, provided the policy is in force.

In the case of a revived Policy, if the Life Assured, whether sane or insane, commits suicide within 12 months of the date of revival of the Policy, higher of 80% of the total premiums paid, if any till date of death or unexpired risk premium value as available on date of death will be payable by Us.

The Policy will terminate on making such a payment and all rights, benefits and interests under the Policy will stand extinguished.

12. Issue of duplicate policy

We shall issue a duplicate of Policy document, on receipt of a written request for the same from You along with the necessary documents as may be required by Us and at such charges as may be applicable from time to time. The current charges for issuance of duplicate policy is Rs. 200. Freelook option is not available on issue of duplicate Policy document.

13. Amendment to policy document

Any variations, modifications or amendment of any terms of the Policy document shall be communicated to you in writing.

PART G

Grievance Redressal Mechanism & List of Ombudsman

1. Customer service

For any clarification or assistance You may contact Our advisor or call Our customer service representative (between 10.00 a.m. to 7.00 p.m., Monday to Saturday; excluding national holidays) on the numbers mentioned on the reverse of the Policy folder or on Our website: www.iciciprulife.com.

Alternatively, You may communicate with Us at any of our branches or the customer service desk whose details are mentioned in the Welcome Letter.

For updated contact details, We request You to regularly check Our website.

i. Grievance Redressal Officer:

If You do not receive any resolution from Us or if You are not satisfied with Our resolution, You may get in touch with Our designated grievance redressal officer (GRO) at gro@iciciprulife.com or 1860 266 7766.

Address:

ICICI Prudential Life Insurance Company Limited,
Ground Floor & Upper Basement,
Unit No. 1A & 2A, Raheja Tipco Plaza,
Rani Sati Marg, Malad (East),
Mumbai- 400097
Maharashtra.

For more details please refer to the "Grievance Redressal" section on www.iciciprulife.com

ii. Grievance Redressal Committee:

If You do not receive any resolution or if You are not satisfied with the resolution provided by the GRO, You may escalate the matter to Our internal grievance redressal committee at the address mentioned below:

ICICI Prudential Life Insurance Company Limited,
Ground Floor & Upper Basement,
Unit No. 1A & 2A, RahejaTipco Plaza,
Rani Sati Marg, Malad (East),
Mumbai- 400097
Maharashtra.

If you are not satisfied with the response or do not receive a response from us within 15 days, you may approach the Grievance Cell of the Insurance Regulatory and Development Authority of India (IRDAI) on the following contact details:

IRDAI Grievance Call Centre (IGCC) TOLL FREE NO:155255
Email ID: complaints@irda.gov.in

You can also register your complaint online at http://www.igms.irda.gov.in/
Address for communication for complaints by fax/paper:

Consumer Affairs Department
Insurance Regulatory and Development Authority of India
Sy.No.115/1, Financial District, Nanakramguda,
Gachibowli, Hyderabad – 500 032.

2. Insurance Ombudsman:

The Central Government has established an office of the Insurance Ombudsman for redressal of grievances with respect to life insurance policies. As per Insurance Ombudsman Rules, 2017 and Insurance Ombudsman (Amendment) Rules, 2021 the Ombudsman shall receive and consider complaints or alleging deficiency in performance required of an insurer (including its agents and intermediaries) or an insurance broker, on any of the following grounds:

a. delay in settlement of claims, beyond the time specified in the regulations, framed under the Insurance Regulatory and Development Authority of India Act, 1999;
b. any partial or total repudiation of claims, by the life insurer, General insurer or the health insurer;
c. disputes over premium paid or payable in terms of insurance policy;
d. misrepresentation of policy terms and conditions at any time in the policy document or policy contract;
e. legal construction of insurance policies in so far as the dispute relates to claim;
f. policy servicing related grievances against insurers, their agents and intermediaries;
g. issuance of life insurance policy, general insurance policy including health insurance policy which is not in conformity with proposal form submitted by the proposer:
h. non-issuance of insurance policy after receipt of premium ; in life insurance and general insurance including health insurance; and
i. any other matter arising from non-observance of or non-adherence to the provisions of any regulations made by the Authority with regard to protection of policyholders' interests or otherwise, or of any circular, guideline or instruction issued by the Authority, or of the terms and conditions of the policy contract, in so far as such matter relates to issues referred to in clauses (a) to (h).

Manner in which complaint to be made

(1) Any person who has a grievance against an insurer or insurance broker, may himself or through his legal heirs, nominee or assignee, make a complaint in writing to the Insurance Ombudsman within whose territorial jurisdiction the branch or office of the insurer or the insurer broker as the case may be complained against or the residential address or place of residence of the complainant is located.

(2) The complaint shall be in writing, duly signed or made by way of electronic mail or online through the website of the Council for Insurance Ombudsmen by the complainant or through his legal heirs, nominee or assignee and shall state clearly the name and address of the complainant, the name of the branch or office of the insurer against whom the complaint is made, the facts giving rise to the complaint, supported by documents, the nature and extent of the loss caused to the complainant and the relief sought from the Insurance Ombudsman.

(3) No complaint to the Insurance Ombudsman shall lie unless—

(a) the complainant has made a representation in writing or through electronic mail or online through website of the insurer or insurance broker concerned the insurer named in the complaint and—

i. either the insurer or insurance broker, as the case may be had rejected the complaint; or
ii. the complainant had not received any reply within a period of one month after the insurer or insurance broker, as the case may be received his representation; or
iii. the complainant is not satisfied with the reply given to him by the insurer or insurance broker, as the case may be;;

(b) The complaint is made within one year—

(i) after the order of the insurer rejecting the representation is received; or
(ii) after receipt of decision of the insurer or insurance broker, as the case may be which is not to the satisfaction of the complainant;
(iii) after expiry of a period of one month from the date of sending the written representation to the insurer or insurance broker, as the case may be if the insurer or insurance broker, as the case may be named fails to furnish reply to the complainant.

(4) The Ombudsman shall be empowered to condone the delay in such cases as he may consider necessary, after calling for objections of the insurer or insurance broker, as the case may be against the proposed condonation and after recording reasons for condoning the delay and in case the delay is condoned, the date of condonation of delay shall be deemed to be the date of filing of the complaint, for further proceedings under these rules.

(5) No complaint before the Insurance Ombudsman shall be maintainable on the same subject matter on which proceedings are pending before or disposed of by any court or consumer forum or arbitrator.

(6) The Council for Insurance Ombudsmen shall develop a complaints management system, which shall include an online platform developed for the purpose of online submission and tracking of the status of complaints made under rule 14

The Ombudsman shall not award compensation exceeding more than Rupees Thirty Lakhs (including relevant expenses, if any).

We have given below the details of the existing offices of the Insurance Ombudsman. We request You to regularly check our website at www.iciciprulife.com or the website of the IRDAI at www.irdai.gov.in for updated contact details.

Office of the Ombudsman	**Address**	**Contact Details**	**Areas of Jurisdiction**
AHMEDABAD	Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad - 380 001	Tel.:- 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat , Dadra & Nagar Haveli, Daman and Diu
BENGALURU	Office of Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560078	Tel No: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka

BHOPAL	Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003.	Tel.:- 0755-2769201, 2769202 Fax : 0755-2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh & Chhattisgarh
BHUBANESHWAR	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009.	Tel.:- 0674-2596455/2596461, Fax : 0674-2596429 Email: bimalokpal.bhubaneswar@cioins.co.in	Odisha
CHANDIGARH	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017	Tel.: 0172 - 2706196 / 2706468 Fax: 0172 – 2708274 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana(excluding Gurugram, Faridabad, Sonepat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.
CHENNAI	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai – 600 018.	Tel.: 044 - 24333668 / 24335284 Fax: 044 – 24333664 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Tamil Nadu Puducherry Town and Karaikal (which are part of Puducherry).

DELHI	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002.	Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
ERNAKULAM	Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015.	Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
GUWAHATI	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001 (Assam).	Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004.	Tel.: 040 - 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR	Office of the Insurance Ombudsman,Jeeva	Tel.: 0141 - 2740363	Rajasthan

	n Nidhi – II Bldg., Gr. Floor,Bhawani Singh Marg,Jaipur - 302 005.	Email: bimalokpal.jaipur@cioins.co.in	
KOLKATA	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor,4, C.R. Avenue, Kolkatta - 700 072	Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001.	Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.

MUMBAI	Office of the Insurance Ombudsman,3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054.	Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA	Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301.	Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA	Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, North Wing Bailey Road, Patna 800001.	Tel.: 0612-2680952 Email: bimalokpal.patna@cioins.co.in	Bihar,Jharkhand

PUNE	Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030.	Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

Annexure I – Unexpired risk premium value factors

For Limited pay:

As per Annexure VIII of the File and Use

Annexure II – Section 39 – Nomination by policyholder

Nomination of a life insurance Policy is as below in accordance with Section 39 of the Insurance Act, 1938, as amended from time to time. The extant provisions in this regard are as follows:

1. The policyholder of a life insurance on his own life may nominate a person or persons to whom money secured by the policy shall be paid in the event of his death.

2. Where the nominee is a minor, the policyholder may appoint any person to receive the money secured by the policy in the event of policyholder's death during the minority of the nominee. The manner of appointment to be laid down by the insurer.

3. Nomination can be made at any time before the maturity of the policy.

4. Nomination may be incorporated in the text of the policy itself or may be endorsed on the policy communicated to the insurer and can be registered by the insurer in the records relating to the policy.

5. Nomination can be cancelled or changed at any time before policy matures, by an endorsement or a further endorsement or a will as the case may be.

6. A notice in writing of Change or Cancellation of nomination must be delivered to the insurer for the insurer to be liable to such nominee. Otherwise, insurer will not be liable if a bonafide payment is made to the person named in the text of the policy or in the registered records of the insurer.

7. Fee to be paid to the insurer for registering change or cancellation of a nomination can be specified by the Authority through Regulations.

8. On receipt of notice with fee, the insurer should grant a written acknowledgement to the policyholder of having registered a nomination or cancellation or change thereof.

9. A transfer or assignment made in accordance with Section 38 shall automatically cancel the nomination except in case of assignment to the insurer or other transferee or assignee for purpose of loan or against security or its reassignment after repayment. In such case, the nomination will not get cancelled to the extent of insurer's or transferee's or assignee's interest in the policy. The nomination will get revived on repayment of the loan.

10. The right of any creditor to be paid out of the proceeds of any policy of life insurance shall not be affected by the nomination.

11. In case of nomination by policyholder whose life is insured, if the nominees die before the policyholder, the proceeds are payable to policyholder or his heirs or legal representatives or holder of succession certificate.

12. In case nominee(s) survive the person whose life is insured, the amount secured by the policy shall be paid to such survivor(s).

13. Where the policyholder whose life is insured nominates his
    a. parents or
    b. spouse or
    c. children or
    d. spouse and children
    e. or any of them

    the nominees are beneficially entitled to the amount payable by the insurer to the policyholder unless it is proved that policyholder could not have conferred such beneficial title on the nominee having regard to the nature of his title.

14. If nominee(s) die after the policyholder but before his share of the amount secured under the policy is paid, the share of the expired nominee(s) shall be payable to the heirs or legal representative of the nominee or holder of succession certificate of such nominee(s).

15. If policyholder dies after maturity but the proceeds and benefit of the policy has not been paid to him because of his death, his nominee(s) shall be entitled to the proceeds and benefit of the policy.

16. The provisions of Section 39 are not applicable to any life insurance policy to which Section 6 of Married Women's Property Act, 1874 applies or has at any time applied. Where nomination is intended to be made to spouse or children or spouse and children under Section 6 of MWP Act, it should be specifically mentioned on the policy. In such a case only, the provisions of Section 39 will not apply.

Disclaimer: This is a simplified version of Section 39 of the Insurance Act, 1938, as amended from time to time. The policyholders are advised to refer to The Insurance Act, 1938, as amended from time to time for complete and accurate details.

Annexure III – Section 38 – Assignment and Transfer of Insurance Policies

Assignment or transfer of a policy should be in accordance with Section 38 of the Insurance Act, 1938, as amended from time to time. The extant provisions in this regard are as follows:

1. This policy may be transferred/assigned, wholly or in part, with or without consideration.

2. An Assignment may be effected in a policy by an endorsement upon the policy itself or by a separate instrument under notice to the Insurer.

3. The instrument of assignment should indicate the fact of transfer or assignment and the reasons for the assignment or transfer, antecedents of the assignee and terms on which assignment is made.

4. The assignment must be signed by the transferor or assignor or duly authorized agent and attested by at least one witness.

5. The transfer of assignment shall not be operative as against an insurer until a notice in writing of the transfer or assignment and either the said endorsement or instrument itself or copy there of certified to be correct by both transferor and transferee or their duly authorised agents have been delivered to the insurer.

6. Fee to be paid for assignment or transfer can be specified by the Authority through Regulations.

7. On receipt of notice with fee, the insurer should Grant a written acknowledgement of receipt of notice. Such notice shall be conclusive evidence against the insurer of duly receiving the notice.

8. If the insurer maintains one or more places of business, such notices shall be delivered only at the place where the policy is being serviced.

9. The insurer may accept or decline to act upon any transfer or assignment or endorsement, if it has sufficient reasons to believe that it is
    a. not bonafide or
    b. not in the interest of the policyholder or
    c. not in public interest or
    d. is for the purpose of trading of the insurance policy.

10. Before refusing to act upon endorsement, the Insurer should record the reasons in writing and communicate the same in writing to Policyholder within 30 days from the date of policyholder giving a notice of transfer or assignment.

11. In case of refusal to act upon the endorsement by the Insurer, any person aggrieved by the refusal may prefer a claim to IRDAI within 30 days of receipt of the refusal letter from the Insurer.

12. The priority of claims of persons interested in an insurance policy would depend on the date on which the notices of assignment or transfer is delivered to the insurer; where there are more than one instruments of transfer or assignment, the priority will depend on dates of delivery of such notices. Any dispute in this regard as to priority should be referred to Authority.

13. Every assignment or transfer shall be deemed to be absolute assignment or transfer and the assignee or transferee shall be deemed to be absolute assignee or transferee, except
    a. where assignment or transfer is subject to terms and conditions of transfer or assignment OR

b. where the transfer or assignment is made upon condition that
   i. the proceeds under the policy shall become payable to policyholder or nominee(s) in the event of assignee or transferee dying before the insured OR
   ii. the insured surviving the term of the policy

Such conditional assignee will not be entitled to obtain a loan on policy or surrender the policy. This provision will prevail notwithstanding any law or custom having force of law which is contrary to the above position.

14. In other cases, the insurer shall, subject to terms and conditions of assignment, recognize the transferee or assignee named in the notice as the absolute transferee or assignee and such person

a. shall be subject to all liabilities and equities to which the transferor or assignor was subject to at the date of transfer or assignment and
b. may institute any proceedings in relation to the policy
c. obtain loan under the policy or
d. the policy without obtaining the consent of the transferor or assignor or making him a party to the proceedings

Disclaimer: This is a simplified version of Section 38 of the Insurance Act, 1938, as amended from time to time. The policyholders are advised to refer to The Insurance Act, 1938, as amended from time to time for complete and accurate details.

Annexure IV – Section 45 – Policy shall not be called in question on the ground of mis-statement after three years

Provisions regarding policy not being called into question in terms of Section 45 of the Insurance Act, 1938, as amended from time to time are as follows:

1. No Policy of Life Insurance shall be called in question on any ground whatsoever after expiry of 3 yrs from
   a) the date of issuance of policy or
   b) the date of commencement of risk or
   c) the date of revival of policy or
   d) the date of rider to the policy

   whichever is later.

2. On the ground of fraud, a policy of Life Insurance may be called in question within 3 years from
   a) the date of issuance of policy or
   b) the date of commencement of risk or
   c) the date of revival of policy or
   d) the date of rider to the policy

   whichever is later.

   For this, the insurer should communicate in writing to the insured or legal representative or nominee or assignees of insured, as applicable, mentioning the ground and materials on which such decision is based.

3. Fraud means any of the following acts committed by insured or by his agent, with the intent to deceive the insurer or to induce the insurer to issue a life insurance policy:
   a) The suggestion, as a fact of that which is not true and which the insured does not believe to be true;
   b) The active concealment of a fact by the insured having knowledge or belief of the fact;
   c) Any other act fitted to deceive; and
   d) Any such act or omission as the law specifically declares to be fraudulent.

4. Mere silence is not fraud unless, depending on circumstances of the case, it is the duty of the insured or his agent keeping silence to speak or silence is in itself equivalent to speak.

5. No Insurer shall repudiate a life insurance Policy on the ground of Fraud, if the Insured / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the policyholder, if alive, or beneficiaries.

6. Life insurance Policy can be called in question within 3 years on the ground that any statement of or suppression of a fact material to expectancy of life of the insured was incorrectly made in the proposal or other document basis which policy was issued or revived or rider issued. For this, the insurer should communicate in writing to the insured or legal representative or nominee or assignees of insured, as applicable, mentioning the ground and materials on which decision to repudiate the policy of life insurance is based.

7. In case repudiation is on ground of mis-statement and not on fraud, the premium collected on policy till the date of repudiation shall be paid to the insured or legal representative or nominee or assignees of insured, within a period of 90 days from the date of repudiation.

8. Fact shall not be considered material unless it has a direct bearing on the risk undertaken by the insurer. The onus is on insurer to show that if the insurer had been aware of the said fact, no life insurance policy would have been issued to the insured.

9. The insurer can call for proof of age at any time if he is entitled to do so and no policy shall be deemed to be called in question merely because the terms of the policy are adjusted on subsequent proof of age of life insured. So, this Section will not be applicable for questioning age or adjustment based on proof of age submitted subsequently.

DISCLOSURES

1. The product is jointly offered by “ICICI Lombard General Insurance Co. Ltd.” and “ICICI Prudential Life Insurance Co. Ltd.”

2. The risks of this ‘Combi Product’ are distinct and are assumed / accepted by respective insurance companies. ICICI Prudential Life Insurance Company Limited shall assume/accept the risk only in relation to the life insurance component of the Combi Product(s) and ICICI Lombard General Insurance Company Limited shall assume/accept the risk only in relation to the health insurance component of the Combi Product(s).

3. The premium of the life insurance and health insurance components of the Combi Product(s) are separate and have been separately identified and disclosed in the Combi Product(s) policy document. The health insurance component of the Combi Product(s) is entitled to be renewed at the option of the policyholder of ICICI Lombard General Insurance Company Limited.

4. The Combi Product(s) shall have a free look option, which shall be applied to the Combi Product(s) as a whole. Provided where an existing policyholder of any health insurance product has migrated to the Combi Product(s), such policyholder is entitled to all the rights of migration as per the applicable portability norms.

5. The liability to settle the claim vests with respective insurers, i.e., for health insurance benefits “ICICI Lombard General Insurance Co. Ltd.” and for life insurance benefits “ICICI Prudential Life Insurance Co. Ltd.”

6. At any time during the validity of the Combi Product(s) policy, you shall be entitled to continue with either part of the Combi Product(s) policy, discontinuing the other. However, in the event you opt out of the coverage of either the life or health insurance component, the discount, being offered to you under the Combi Product (s) shall not be available going forward.

7. All policy servicing requests pertaining to the Combi Product(s) shall be received by either of the Insurers. However, ICICI Lombard General Insurance Company, as the Lead Insurer of the Combi Product(s), shall play a facilitative role in policy servicing and shall be the nodal point for receiving the servicing requests, executing these requests and issuing acknowledgements as required.

8. The legal/quasi legal disputes, if any, are dealt by the respective insurers for respective benefits.

9. The policyholders of the ‘Combi Product’ under reference are eligible to continue with either part of the policy, discontinuing the other during the policy term. The legal

disputes pertaining to life insurance benefits shall be dealt with by ICICI Prudential Life Insurance Company Limited and for health benefits all the legal disputes will be handled by ICICI Lombard General Insurance Company Limited.

10. Where guaranteed renewability of health insurance plan is allowed, the health insurance portion of this 'Combi Product' is entitled to that facility.

11. The available Grievances Redressal Options including particulars of Ombudsman under these 'Combi products' are specified under Standard General Terms and Conditions section of the Policy Document.

12. Policyholders are to be advised to familiarize themselves with the policy benefits and policy service structure of the 'Combi Product' before deciding to purchase the policy.

13. Combi product discount:

Discount of 5% on annual premiums paid towards Health policy (ICICI Lombard - Health AdvantEdge) will be offered as compared to the individual policy purchased under Health & Life separately. At any time during the validity of the policy, if the customer decides to opt out of the insurance coverage of one of the Insurer, the discount, if any, being offered to such customer under the Combi-Product(s) shall not be available to going forward.

14. The customer has the option of cancelling only their Health Policy and continue with the Life insurance cover or vice a versa subject to extant regulations and guidelines pertaining to Combi product. However in that case, the customer will have to forfeit the 5% combi plan discount as was applicable on the Policy and the change of policy will be subject to Migration guidelines.

15. Withdrawal of Tie-up between the insurers:

Any insurer may terminate this tie up wholly or in part only with cause and after making a joint application for the requisite approval from IRDAI. The insurers agree that upon receipt of such approval from IRDAI, the insurers may terminate this tie up within a period of 90 (ninety) days from the date of such approval. The insurers may mutually decide to terminate the Agreement and intimate the same to the customer ninety (90) days prior to the termination of the relationship. However, the Policy will continue until the expiry or termination of the coverage in accordance with the policy wordings for respective coverage.

In case of withdrawal of tie-up between insurers, the customer may choose to continue with either of the policies (health or life). However, the same will be subject to Migration guidelines.